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**Service User Perceptions of Safety
within Organisational Care Transfers
and Development of a Service User
Reporting Mechanism**

JASON SCOTT

PhD

2012

**Service User Perceptions of Safety within
Organisational Care Transfers and
Development of a Service User Reporting
Mechanism**

JASON SCOTT

**A thesis submitted in partial fulfilment of the
requirements of the University of Northumbria at
Newcastle for the degree of Doctor of Philosophy**

**Research undertaken in the School of Health,
Community and Education Studies and in
collaboration with the North East Strategic Health
Authority**

2012

Abstract

Introduction

Patient safety incidents have been suggested to occur in approximately 20% of organisational care transfers, based upon healthcare professional reporting. In other areas of healthcare, service users have been reported to define safety differently to healthcare professionals and identify more and different types of safety incidents. This study explored patient perceptions of safety, which informed the development of a mechanism that allowed service users to report on their safety during an organisational care transfer.

Methods

Appreciative Inquiry (AI) and Action Research (AR) were utilised over 2 phases. Phase 1 (AI) explored perceptions of safety with 14 service users recruited from 3 NHS community care teams, 2 social care homes and 2 private nursing homes. Phase 2 (AR) developed the reporting mechanism, a safety survey, through 2 workshops with healthcare professionals and service users. 240 surveys were distributed to the 3 NHS community care teams, 2 social care homes and 1 private nursing home during two rounds of piloting.

Findings

Service user perceptions indicated 4 different domains of safety; communication, responsiveness, traditional safety issues and trust. The safety survey was based upon these perceptions, capturing how safe service users felt over three stages of an organisational care transfer; departure, journey and arrival. Over two rounds of piloting, 152 surveys were distributed to service users, with 63 (41%) responding. 19 (30%) reported feeling unsafe in at least one domain over the three stages. This was greater than the 20% of incidents reported by healthcare professionals.

Discussion

Service users perceived safety differently to and reported more incidents than healthcare professionals. The domains of safety that were identified formed additional safety buffers within the Swiss-Cheese model of safety. Although the reporting mechanism was inhibited by organisational changes, it performed the function of highlighting safety concerns; an essential process in uncovering recurrent error traps. Organisations should attempt to capture how safe service users have felt when arriving or departing from their service to provide a detailed analysis of safety in order to reduce the recurrent errors.

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Finally I would like to express thanks to my family and friends for providing support throughout for helping to keep me sane. Stephanie in particular has kept me focused throughout the most difficult part of writing the thesis.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others. The work was done in collaboration with the North East Strategic Health Authority.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the School Research Ethics Committee and Sunderland NHS Research Ethics Committee.

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Signature:

Date:

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Appendix 16:	Scott, J., Dawson, P. & Jones, D. (2011). Do older patients' perceptions of safety highlight barriers that could make their care safer during organisational care transfers? BMJ Quality and Safety, doi: 10.1136/bmjqs-2011-000300

Abbreviations

AI	Appreciative Inquiry
AR	Action Research
ASP	Ambulance Service Paramedic
ASSA	Ambulance Service Safeguarding Adults lead
AvMA	Action against Medical Accidents
CCG	Clinical Commissioning Group
CCTN	Community Care Team Nurse
CQUIN	Commissioning for Quality and Innovation
EP	Expert Patient
GP	General Practitioner
ICPS	International Classification of Patient Safety
IF	Improvement Foundation
LINKs	Local Involvement Networks
NEAS	North East Ambulance Service
NESHA	North East Strategic Health Authority
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
NUSU	Northumbria University Service User
OGIMs	Objectives, Goals, Initiatives, Measures
PALs	Patient Advice and Liaison service
PCHM	Private Care Home Manager
PCPE	Patient, Carer and Public Engagement network
PCT	Primary Care Trust
PPI	Patient and Public Involvement
PROM	Patient Reported Outcome Measure
PSAT	Patient Safety Action Team
R&D	Research and Development
REC	Research Ethics Committee
SCHM	Social Care Home Manager
SCNE	Safer Care North East
SHA	Strategic Health Authority
SHAR	Strategic Health Authority Representative
SPO	Structure-Process-Outcome model
SUIs	Serious Untoward Incident
UK	United Kingdom
WHO	World Health Organisation

Chapter 1: Introduction

1.1 Chapter Overview

This chapter provides an introduction to the study, beginning with a brief overview of the research topic and how it was identified through meetings between the researcher, the supervision team and the North East Strategic Health Authority (SHA). The research question is then stated, followed by a clarification of the different terminology used throughout the study. Finally the content of each chapter is described.

1.2 Background

Patient safety is a relatively new, but now widely recognised term within modern healthcare. The increased recognition is due in part to the release of influential reports by the UK's Department of Health and USA's Institute of Medicine, and previously to these reports, work by influential pioneers such as Bill Runciman, Charles Vincent, James Reason and Sir Liam Donaldson to name a few, which have spurred on what can be called a social movement. The result of this movement is a relative increase in the safety of healthcare, but it is the awareness of safety issues that is the most important, as without this it would not be possible to drive improvement.

Despite the advances that have been made, this movement is still relatively in its infancy. As such there are still many gaps that require further exploration, in part a result of the vast and complicated nature of modern healthcare. These gaps are further expanding as the health needs of the population change, technology advances, healthcare roles develop and healthcare policy encourages an increased emphasis on patient and public involvement.

It is partially for these reasons that this research project developed as it did. Although there is an increasing amount of research exploring how patients can become involved in their own safety, there have been fewer studies focusing on how patients perceive safety, and the role that they can play in reporting instances of their experiences of safety.

Discussions between the researcher, supervision team and the North East SHA at the outset of the study highlighted the need for research into the clinical theme of 'care transfers, handovers and discharges (inter-disciplinary and inter-agency working)'. In the UK, most service users undergo a transfer of some type, including admissions, discharges and handoffs both within and between organisations. These care transfers are an area of healthcare particularly high in risk, and one in which the patient perspective is critical to any

attempt to measure quality of care. This study focused specifically on transfers between organisations. It was these considerations that helped to frame the research aims, objectives and design, and from which the study developed.

1.3 Research Question

Underpinned by the points above, two research questions were developed that were intrinsically linked together;

1. How do service users who have undertaken an organisational care transfer perceive safety?
2. What would facilitate service users to report instances of safe and unsafe care?

1.4 Terminology Used in the Study

Within healthcare there is an on-going debate regarding the most appropriate term to use when referring to a recipient of healthcare (McLaughlin, 2009). Two common names include patient and service user, however the terms client, customer or consumer are also referred to in the literature, with each having slightly different meanings (McLaughlin, 2009). Service user is used mainly in this study as it draws comparisons with the philosophical approaches of the study, whilst patient is used to create continuity with the body of existing literature. As a result, these two terms are often used interchangeably throughout. Service user can also include those not directly receiving the healthcare but are impacted upon by it or a witness to it, such as family members, carers or advocates.

Similarly there is a plethora of terms for those that provide healthcare; too many to list here. Therefore the term healthcare professional will be used throughout this study to refer to anyone involved in the provision of healthcare, such as but not limited to doctors, healthcare managers, nurses, and paramedics.

Finally it is important to define a care transfer; a relatively simple term that has more complicated implications. Within health services, a service user's care is often passed from one team or organisation to another; sometimes without the patient needing to physically move and other times having to be transported to and from wards, hospitals, community settings and care homes. It is for this reason that an organisational care transfer, the focus of this study, refers explicitly to care transfers where the service user moves between organisations, such as but not limited to being discharged from hospital into community care,

being admitted to hospital from a care home or being discharged from a care home to their own private home, with or without support.

Within this study the common terms of admission (entering a service), discharge (exiting a service) and handovers (moving between services) are all given the encompassing title of an organisational care transfer when discussed as a single entity. However in places they are still referred to as their individual components, for example in some studies only one component was explored. The reporting mechanism developed in this study also breaks the organisational care transfer down to three components; the departure (discharge), journey and the arrival (admission).

1.5 The Structure of the Thesis

Chapter 1 has given a general introduction to the thesis and an overview of the structure. **Chapter 2** provides a broad and in-depth analysis of the literature relating to the study; both academic- and policy-related. Safety is explored from a historical perspective, focusing on lessons that have been learned from aerospace and engineering industries, before progressing onto the recent patient safety movement. Included in this is an overview of quality improvement, organisational cultures and psychology and the role that social sciences can play in patient safety, as well as widely cited models of patient safety. Organisational care transfers as outlined above are then discussed. The different types of transfer are explored along with the many potential risks that exist and the current initiatives within the region to make them safer. Patient and public involvement is also explored with an overview of the theory and policies on involvement, moving into the related areas of patient satisfaction, the role that expert patients play in their healthcare and how patients can become involved in their own safety. Finally the chapter concludes with a summary of how each of these individual aspects tie together to give a rationale for this study, along with a restatement of the aims and objectives framed within this rationale.

Chapter 3 introduces the epistemological and ontological assumptions of the study which sit within critical realism. These are framed within the methodological approaches of Appreciative Inquiry (AI) and Action Research (AR) that have been utilised, and provides reflections on the process of working in a collaborative environment with various organisation types. Also addressed in this chapter is how AI, a form of AR itself, has been combined with a more traditional AR process. A diagram of how the different stages link together is provided, which is also reintroduced throughout each of the findings chapters to depict where each finding fits within the methodological framework.

Chapter 4 presents the methods that were used in each of the individual phases and stages of the study. Firstly these relate to Phase 1, where the recruitment of participants, the sampling framework and the data collection and methods of analysis are discussed. These particularly focus on the exploration of safety with service users through appreciative interviewing. Phase 2 then focuses on the process of developing the reporting tool, accomplished through two workshops with a wide range of stakeholders; predominantly healthcare professionals and service users. How the tool was piloted by these healthcare professionals is then discussed, along with an overview of the evaluation that was conducted simultaneously. Following this, the ethical considerations are discussed along with an outline of the required ethical approvals that were required for the study to progress. Finally an overview of how the findings are presented over the following three chapters (5, 6 and 7) is provided via a flow chart depicting the study phases, the methodology and methods that were utilised and the chapter each of these is reported in.

Chapters 5, 6 and 7 explore the findings of the first and second phases of the study. In **Chapter 5** a thematic overview of Phase 1 is provided, along with a discussion of the implications of these findings and how they link in to the philosophical framework. In **Chapter 6** the findings from the development of the reporting tool are explored over the two workshops, along with a detailed analysis of how the reporting mechanism came together from the data. In this chapter the data is used as a resource to evidence why the reporting mechanism took the form that it did. **Chapter 7** provides the findings from the reporting mechanism which are detailed within the cyclic processes of AR; exploring how the reporting mechanism was distributed to service users (Action), the reports of safety provided by service users (Observation) and how the reporting mechanism was revised over two cycles based upon an evaluation (Reflection).

Chapter 8 restates the aims and objectives of the study before providing a discussion of the findings. It is here that the findings are interpreted to present meaning, along with possible alternative explanations. The findings are also discussed in relation to models and theories of safety, with an explanation of how the findings contribute to the further development of these. The implications that this has upon practice and explicit areas of the study that require future research are then presented along with the limitations of the study. Finally the thesis is framed in a time within the current political landscape of changes to healthcare. This receives particular attention due to the time of writing the thesis; a time when economic recession and a change in Government have brought about unprecedented and far reaching changes to healthcare in the UK.

1.6 Contributions to Knowledge

This study provides original contributions to knowledge on three levels: conceptual, practical and methodological. At the conceptual level, patient perceptions of safety when going through an organisational care transfer are presented and applied to the Swiss-Cheese model of safety. Patient perceptions of safety, in particular communication and responsiveness, formed additional barriers, defences and safeguards. The reporting mechanism developed thus allowed patients to report on any holes in these safety barriers that may have impacted upon their safety, which offers a new practical solution to patient reporting of safety during organisational care transfers. The applicability of the patient perceptions of safety to the Swiss-Cheese model of safety have since been published (Scott, Dawson, & Jones, 2011, Appendix 15).

The use of Appreciative Inquiry offers a unique methodological contribution to knowledge by approaching patient safety research from a positive stance, which helps to reduce cultural and personal barriers often associated with researching safety, where patients may be unwilling to be critical of their healthcare. The novel combination of Appreciative Inquiry and Action Research adds to the methodological contribution through the process of development and piloting of the reporting mechanism, which provided an opportunity for healthcare professionals and service users to contribute equally, whilst ensuring it was still based upon service user perceptions of safety.

Chapter 2: Literature Review

2.1 Chapter Overview

This chapter provides an overview and analysis of the literature relating to three key aspects of the study; patient safety, organisational care transfers and patient and public involvement. Although all three of these are intrinsically linked, they are reported individually. Both theory and policy are discussed in these sections. The chapter ends with a summary and a statement of how the aims and objectives link in to the current literature.

2.2 Introduction to Patient Safety

2.2.1 What is Patient Safety?

Patient safety has been a long-standing feature within the field of medicine dating as far back as the Ancient Greeks; in particular with the Hippocratic Oath, that when translated into modern healthcare has come to mean 'first do no harm'. Despite this ethical stance, patient safety was either unrecognised by healthcare professionals as a serious risk to the patient or its seriousness was previously not acknowledged (Vincent, 2010).

Other critical perspectives of iatrogenic harm include the likes of Illich (1977), who whilst comparing healthcare to Greek mythology suggested that direct iatrogenic harm (clinical iatrogenesis), along with increasing healthcare costs (social iatrogenesis) and an increased inability to cope with pain and death (cultural iatrogenesis) were the result of the medicalization of society. These can come from direct medical care, healthcare policies, industry, an increased reliance upon healthcare and medicine and the restriction of individual autonomy. An alternative way to see iatrogenic harm is that failure is inevitable (Bosk, 1979), with learning from past experiences being the most effective way of reducing failure. It is this approach that resonates most closely with existing work on patient safety that attempts to reduce iatrogenic harm in a manner similar to epidemiological studies.

Although it is recognised that societal and cultural factors, similar to those identified by Illich, can have a large impact upon patient safety, these are not the focus of this chapter, nor subsequently the thesis as a whole. Similarly this thesis does not attempt to develop or incorporate theories of learning or socio-cultural conflict (e.g. Douglas & Wildavsky, 1982). Instead this study addresses patient safety from a practice-based stance, developing a patient reporting mechanism based upon patient perceptions of safety in a manner similar to existing methods of incident identification, such as healthcare professional reporting. More

specifically, patient safety in this study is seen as the prevention or avoidance of harm to service users during their episode of healthcare, as perceived by the service user, which incorporates organisational improvement.

Such epidemiological studies are based on early research into patient safety that not only attempt to identify safety incidents but also to resolve the underlying causes. An early example is that of Florence Nightingale who, whilst widely recognised for her contribution to nursing was also a pioneering medical statistician. During the Crimean War in 1855 she decreased death rates in her hospital from 42.7% to 2.2% within months by introducing sanitary reforms (Neuhauser, 2003). A more recent example is provided in the work of Barrett-Connor (1972), who after a comparison of healthcare acquired infection rates amongst short- and long-stay patients, identified that those in short-stay hospital care suffered from fewer infections. Healthcare acquired infections remain a prevalent issue on a worldwide basis, with the World Health Organisation (WHO) initiating a global patient safety challenge aimed at tackling the issue, emphasising hand-washing to reduce the number of healthcare acquired infections (Pittet, 2010).

These examples of patient safety highlight one aspect of the continuous drive to improve the quality of healthcare, and is summarised by the WHO, who define quality as 'a process of meeting the needs and expectations of patients and health service staff' (WHO, 2000). Buetow and Roland (1999) present an overview of the different terms and definitions of quality that appear within healthcare, such as quality assessment, quality assurance, clinical audit and continuous quality improvement. Although slightly different in their philosophies and methods, they each have a similar aim of increasing the standard of care or performance of healthcare professionals. It is recognised that each has its own philosophies and methods that reflect particular disciplinary tensions, in particular between managers and professionals (Buetow & Roland, 1999).

Avedis Donabedian, who has been recognised to be one of the most instrumental figures in the field of quality assurance (Best & Neuhauser, 2004), has given a brief account of some of the differing terms. He argues that as one cannot assure or guarantee quality, and that perfect quality is unattainable, the term assurance is a fallacy. Instead, healthcare professionals should strive to continuously increase quality with an unachievable end target in sight (Donabedian, 2003).

Donabedian also states that there are seven components of healthcare quality; efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy and equity (Donabedian, 2003), as defined in Table 2.1.

Components of Quality	Definition
<i>Efficacy</i>	Ability of science and technology to bring about improvements in health when used under the most favourable circumstances
<i>Effectiveness</i>	The degree to which attainable improvements in health are, in fact, attained
<i>Efficiency</i>	The ability to lower the cost of care without diminishing attainable improvements in health
<i>Optimality</i>	The balancing of improvements in health against the costs of such improvements
<i>Acceptability</i>	Conformity to the wishes, desires and expectations of patients and their families
<i>Legitimacy</i>	Conformity to social preferences as expressed in ethical principles, values, norms, mores, laws and regulations
<i>Equity</i>	Conformity to a principle that determines what is just and fair in the distribution of healthcare and its benefits among members of the population

Table 2.1: Seven components of healthcare quality (Donabedian, 2003).

Although Donabedian does not explicitly discuss patient safety as being part of these seven components of healthcare quality, it still appears to fall within the definition of effectiveness. Any iatrogenic harm to a patient invariably results in a decline of health despite aiming for an attainable improvement. As such this decline in health would result in a poorer quality of care than if the healthcare had been unsuccessful but without harm. A graphical representation of a patient's wellness can be found in Figure 2.1, where the blue line represents best care and the red line represents the effectiveness of the same care if the patient was to experience iatrogenic harm, such as having a fall during their hospital stay. This is not a definitive statement that the patient can or will return to the same health status as iatrogenic harm can result to permanent morbidity or even mortality. This matches closely with the Department of Health's (2008a) definition of quality, which states that quality care is clinically effective, personal and safe. Donabedian also produced a model of healthcare quality measurement (Structure-Process-Outcome), which will be discussed later in the chapter.

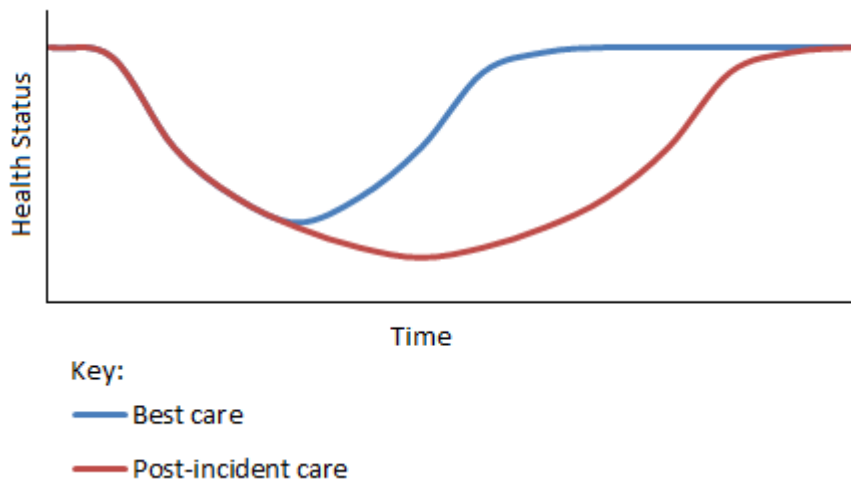


Figure 2.1: Graphical presentation of effectiveness of care pre- and post-patient safety incident (adapted from Donabedian, 2003, p. 7).

Patient safety generally has a single definition with constituent parts (Table 2.2), although it has been identified that this can vary between organisations (Donaldson, 2009). The single definition states that a patient safety incident is ‘any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care’ (National Patient Safety Agency, 2009). This includes both adverse events, an ‘event or omission arising during clinical care and causing physical or psychological injury to a patient’ (2000b, p. xii), and near-misses, a ‘situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient’ (Department of Health, 2000b, p. xii).

Term	Definition
<i>Patient safety incident</i>	Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care
<i>Adverse event</i>	An event or omission arising during clinical care and causing physical or psychological injury to a patient
<i>Near-miss</i>	A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient
<i>Never event</i>	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented

Table 2.2: Definitions of common terms used in patient safety literature.

Although these definitions are generally accepted within the UK, there are still discrepancies that arise on local, national and international levels. The World Health Organisation (WHO) World Alliance for Patient Safety have aimed to define each of the terms that are used in patient safety research in an attempt to create congruence in the systematic collection, aggregation, and analysis of relevant information (Runciman, et al., 2009; Sherman, et al., 2009; Thomson, et al., 2009). The terms listed above and used in this study reflect those that make up the International Classification of Patient Safety.

As well as the different terms used to explain what a patient safety incident is, there are also different levels of harm that can arise from an incident. These range from no harm incidents through to death (Table 2.3), and are used by the National Patient Safety Agency (NPSA) and individual organisations when analysing the number of patient safety incidents that have been reported. There are also a number of ‘never-events’ (Department of Health, 2011), which at the time of writing are 25 “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented” (NPSA, 2010a, p. 3), independent of their level of harm to the patient.

Severity of Patient Safety Incident	Definition
<i>No harm: Impact prevented</i>	Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm
<i>No harm: Impact not prevented</i>	Any patient safety incident that ran to completion but no harm occurred
<i>Low harm</i>	Any patient safety incident that required extra observation or minor treatment and caused minimal harm
<i>Moderate harm</i>	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm
<i>Severe harm</i>	Any patient safety incident that appears to have resulted in permanent harm
<i>Death</i>	Any patient safety incident that directly resulted in death

Table 2.3: Definitions of levels of harm (NPSA, 2011a)

2.2.2 Healthcare Policy on Patient Safety

Quality and in particular patient safety is now a central tenet of the NHS, with the NHS Plan (Department of Health, 2000a) and the recent white paper 'Equity and excellence: Liberating the NHS' (Department of Health, 2010a) both emphasising the objectives of reducing mortality, increasing safety and improving patient experiences that are a common discourse in healthcare policies.

Although these are now clearly defined objectives of the NHS, patient safety has only recently received this level of attention. At the turn of the millennium the Department of Health (2000b) published 'An Organisation With a Memory', whilst in America the Institute of Medicine released 'To Err is Human' (Kohn, Corrigan, & Donaldson, 2000). Both of these reports have been hugely influential and are generally regarded as catalysts for the improvement in patient safety that is becoming synonymous with 21st century medical care. It is these reports that were the first to widely acknowledge the potential for healthcare to harm those that it is trying to help and shift the focus of healthcare policy and practice towards providing safe care.

From 'An Organisation With a Memory', the Department of Health outlined four key areas that must be addressed; mechanisms for reporting and analysing incidents, an open culture instead of a blame culture, mechanisms to implement safety recommendations and an

improved awareness of the system approach to safety. The arms-length body named the National Patient Safety Agency was formed on the back of 'The NHS Plan' (Department of Health, 2000a) to achieve these aims. In particular they state that their aims are to "lead and contribute to improved, safe care by informing, supporting and influencing organisations" (NPSA, 2011b).

A later review of patient safety, 'Safety First' (Department of Health, 2006), aimed to assess if the organisational structures for patient safety placed safety at the centre of all healthcare. The review claimed that although there had been large improvements in awareness of patient safety issues, they were not receiving the same levels of attention as other initiatives such as waiting times, financial balance and the implementation of National Service Frameworks. It was highlighted again that patient safety needs to be at the core of all policy and delivery from the policymakers to clinicians on the frontline. The NPSA was seen as being central to policy by improving its ability to influence learning at a local level and influencing the change from a blame culture to one of being open. A 'culture of open information, active responsibility and challenge' is encouraged in order to stop major incidents from occurring (Department of Health, 2009b).

A fundamental change to the structure of the NHS was proposed by the coalition government in the White Paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010a), despite the previous Secretary State for Health stating shortly before that the 'NHS is in good health' (Department of Health, 2008a, p. 3). The new structure of the NHS proposes to make commissioning of services the responsibility of Clinical Commissioning Groups (CCGs); multiple consortia consisting mostly of General Practitioners (GPs) along with other healthcare professionals instead of the Primary Care Trusts (PCTs), with the intention of making services more responsive to patient needs. Spending will continue to increase in real terms year-on-year, although efficiency savings of around £20 billion are required by 2014. At the same time the White Paper emphasised the need for the NHS to remain free at the point of use and based on clinical need, not the ability to pay. A wider discussion of the reforms to health and social care and the political landscape of patient safety is provided in the discussion chapter, focusing in particular on how they relate to the findings from this study.

With regards to patient safety, the NPSA is currently being dissolved in its current form (Department of Health, 2010b), with individual functions being moved to other organisations. In particular, the National Reporting and Learning System (NRLS), the central system for healthcare organisations in the UK to report and learn from patient safety incidents, will still

function as a sub-committee of the NHS Commissioning Board (Department of Health, 2010b). Other functions, such as research ethics and confidential enquiries will not be part of the NHS Commissioning Board's functions, but as part of a Health Research Agency and the Healthcare Quality Improvement Partnership respectively.

The continued presence of quality and safety at the forefront of healthcare policy, despite the extensive restructuring of the NHS, emphasises that they are both central components of modern healthcare. However this raises the question of why there is a need to improve patient safety.

2.2.3 The Need to Improve Patient Safety

When compared to other risky organisations and activities, such as chemical and nuclear industries, chartered flights and road safety, healthcare has been reported to be higher in risk (Amalberti, et al., 2005). Both the Department of Health (Department of Health, 2000b) and Institute of Medicine (Kohn, Corrigan, & Donaldson, 2000) reported that safety incidents occur in around 10% of all admissions, citing Vincent, Neale and Woloshynowych (2001) who conducted a retrospective record review of 1014 medical records. From these incidents they found that around half were preventable, whilst Smits et al. (2010) in a similar retrospective patient record review found 61% of adverse events were preventable.

Over time these estimations have remained relatively stable, and similar rates of patient safety incidents can be found in other healthcare systems regardless of how they are composed, such as America (Kohn, Corrigan, & Donaldson, 2000) , Australia (Wilson, et al., 1995), Brazil (Mendes, et al., 2009), Canada (Baker, et al., 2004), New Zealand (Davis, et al., 2002) and Sweden (Soop, et al., 2009). This research also supports Vincent et al. (2001), and more recently Smits et al. (2010), who found that around half of the adverse events identified are preventable. Developing countries fare even worse, with research suggesting that their levels of healthcare acquired infections are considerably greater than developed counties (Allegranzi, et al., 2011).

Within the UK, it has been estimated that patient safety incidents affect between 850,000 (Department of Health, 2000b) and 974,000 (National Audit Office, 2005) patients. There is the potential for many more to be included, with the National Audit Office (2005) recognising that these are only the number of reported incidents, excluding hospital acquired infections which may increase the figure by a further 300,000.

As would be expected, there are a number of fiscal costs in addition to the human costs associated with adverse events, which include litigation and also the cost of care to treat the iatrogenic illnesses. In 2000, around £400 million a year was paid out in litigation, with a potential liability of £2.4 billion for cases that didn't result in litigation (Department of Health, 2000b). Again, this does not include hospital acquired infections, which cost a further £1 billion a year. The exact value is not known as identifying every incident and their costs is not possible due to a number of reasons, including the sheer scale of the problem and issues around accurate reporting by healthcare professionals.

A further complication is that due to the complex nature of modern healthcare, there are many different types of patient safety incidents that occur in many different healthcare settings and for a variety of reasons (Zegers, et al., 2011). Some examples of incident categories include healthcare acquired infections, falls, medication, missed- or mis-diagnosis and surgery-related incidents. Each of these can be broken down further, for example medication can focus on errors in prescribing, dispensing or administering drugs. Efforts to reduce the number of incidents have been relatively successful, such as checklists (Ko, Turner, & Finnigan, 2011), which reduce the number of patient safety incidents in surgery by 36% (Haynes, et al., 2009) and healthcare acquired infections by almost 50% (Fuchs, et al., 2011). However in order to reduce safety incidents on a large scale, it is necessary for healthcare professionals to identify and report them. Without doing so, the incidents can often go unnoticed, their root causes may not be accurately identified or they may be actively hidden.

Despite some clear progress such as the introduction of checklists, Vincent et al. (2008) summarise that there is insufficient data to accurately state if healthcare is becoming safer, partly due to inadequate measures of safety. A further reason is that the number of incidents reported each year are increasing, although it is unknown if this is a result of healthcare becoming less safe, or paradoxically from becoming more safe as a result of changing cultures and increased reporting of incidents.

2.2.4 Role of Patient Safety Cultures and Systems

There are a number of models of patient safety that aim to identify the causes, components, processes and structures that are involved in patient safety incidents. The models discussed below include the Structure-Process-Outcome (SPO) model of quality, the Swiss-Cheese model of safety and the ICPS which display similar characteristics to each other. These are

discussed due to their prominence in the patient safety literature and because they draw from the interlinked constructs of safety and quality.

The Structure-Process-Outcome (SPO) model of quality that was proposed by Donabedian (1966) factors in the structural aspects of a healthcare organisation (material resources, human resources and organisational characteristics), the processes of healthcare (activities such as diagnosis, treatment, rehabilitation) and the outcomes of healthcare, either desirable or undesirable (changes in health status, knowledge, behaviour and satisfaction). It has since been applied to patient safety by Battles and Lilford (2003) who state that patient safety research needs to focus on the causes of safety incidents (both the structures and processes) in order to minimise harm to patients (the outcome), and by doing so it is possible to identify and address these causes.

By applying Donabedian's SPO model of quality to patient safety in a cultural context, the organisational culture can be interpreted as the structure in which safety exists. Therefore the implementation of a systems approach is the process by which safety is explored and the reporting of incidents can be seen to be the outcome.

In many instances, human error has been identified as the cause of safety incidents both inside and outside of healthcare. There are two different approaches that can be taken to human error; the person-centred and the systems approach. The person-centred approach states that if a human error is made, it is at the fault of the individual, either for forgetfulness, inattention, poor motivation, carelessness, negligence or recklessness (Reason, 2000). In order to stop future errors from occurring, any variability in behaviour is discouraged and the individual is often reprimanded for their mistake. Other sanctions include the threat of litigation and the attempt to embarrass the individual through 'naming and shaming' so that they will not make the same mistake again. Organisations that adopt this approach are said to have a blame culture, which remains very common in healthcare in the UK (Woodward, Lemer, & Wu, 2009).

Collins et al. (2009a) suggest that there are three types of blame; self-blame, blame of impersonal forces (the system) and blame of others. When a human error occurs, it is argued that self-blame is the most prevalent of these, with blaming others only occurring when a clear violation of care has occurred and only as a last resort. Furthermore Collins et al. (2009a) claim that blame can be beneficial to the learning and growth of physicians. However a major flaw of this study is that they only take into account blame from physicians without considering that physicians are part of a multidisciplinary team consisting of many

different healthcare professionals and managers, which generate issues around power and authority. In a later article the same authors (Collins, et al., 2009b) state that a cultural combination of openness and blame is the most effective way of improving safety, which has been supported by Mardon et al. (2010). Woodward, Lemer and Wu (2009) refute this, stating that a widespread move towards a systems approach is necessary in order to break away from the many negative outcomes that a blame culture brings with it.

Despite some opposing research such as by Collins et al. (2009a, 2009b) and Mardon et al. (2010), it is widely accepted that a blame culture results in a greater chance of individuals covering up errors due to a fear of retribution, acting as a barrier to the true cause of the error being uncovered. It is for this reason that the move away from a blame culture to one of being open has received much support in both literature and policy (e.g. Department of Health, 2000b; Reason, 1998, 2000; Waring, 2005; Woodward, Lemer, & Wu, 2009). In particular, a patient safety culture, defined as 'the willingness and ability of an organisation to understand safety as well as the willingness and ability to act on safety' (Reiman, Pietikainen, & Oedewald, 2010), is necessary for the effective reporting of safety incidents that is central to the systems approach to safety.

The systems approach still recognises that human error is a major cause of safety incidents, however instead of attributing blame to individuals, the blame is instead attributed to the systems in which the individuals work. Reason (1995) states that human error is "more a matter of opportunity than the result of excessive carelessness, ignorance, or recklessness" (p.3), and by removing the opportunity the error is less likely to occur. Comparing the systems approach to the SPO model results in a similar conclusion, where human error is an outcome of poor structures and processes. The emphasis of the systems approach is on identifying the systems that cause an incident to occur, which requires the reporting of incidents and near misses so that the root causes can be analysed and addressed. Without doing this, "we have no way of uncovering recurrent error traps or of knowing where the "edge" is until we fall over it" (Reason, 2000, p. 768).

It has previously been acknowledged that within healthcare there is currently a blame culture (Olsen & Aase, 2010; Waring, 2005), and as such there have been many attempts to manufacture a culture of being open with consistent reporting of safety incidents (Department of Health, 2000b). Because organisational cultures do not appear out of nowhere, but instead are dynamic entities that evolve over time (Reason, 1998) either through natural growth or systematic alteration by management (Ouchi & Wilkins, 1985), it has been shown that it is possible for them to be transformed. This is made more difficult

because regardless of the type of culture inherent in institutions, Deilkas and Hofoss (2010) suggest that individual cultures can exist in individual departments, meaning that any exploration of cultures needs to occur as closely as possible to the patient, therefore reinforcing the role of the patient voice.

A central component of the systems approach to safety is the Swiss-Cheese model (Reason, 2000) which proposes that defences, barriers and safeguards are essential in reducing the impact of any error that may occur. These can come in many forms, such as engineered (alarms, physical barriers etc.), human (physicians, nurses etc.), procedural (checklists, medication instructions etc.) and administrative controls (medication dispensing etc.). However the different types of defences (layers of Swiss-Cheese) are not perfect, but in fact have holes in them which are constantly changing and moving.

According to this model of safety, an incident will occur when the holes in each layer line up, allowing a hazard to come into contact with the patient. These holes occur for a number of reasons, but are categorised into active and latent failures. Active failures are described as being the 'unsafe acts committed by people who are in direct contact with the patient or system' (Reason, 2000). They include any form of a slip, lapse, mistake or procedural violations and within the person-centred approach they are where the blame resides.

Latent failures occur as a result of long-standing problems that exist in the system. These can include problems in the local workplace (time pressure, understaffing, inadequate equipment etc.) or longstanding weaknesses in the defences (unworkable procedures, broken physical barriers etc.). Latent conditions can often exist for a sustained period of time without causing any harm, but when aligned with active failures can have the potential to lead to a patient safety incident. Figure 2.2 presents a visual representation of the Swiss-Cheese model of patient safety.

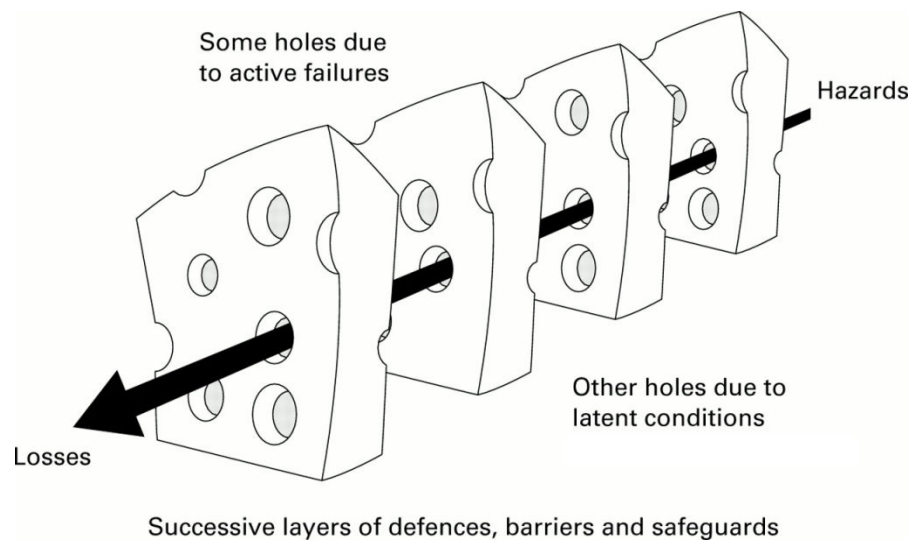


Figure 2.2: Swiss-Cheese model of safety. Reproduced from BMJ Quality and Safety, Reason, Carthey & de Leval (2001), Volume 10 (Supplement ii), with permission from BMJ Publishing Group Ltd.

Since Donabedian (1966, 1988, 2003) and Reason (2000) introduced their models of quality and safety respectively, there has been a move towards producing an ICPS. This included introducing standard definitions of concepts related to patient safety (see Runciman, et al., 2009), as well as producing a conceptual framework (Figure 2.3) (Runciman, et al., 2010; Sherman, et al., 2009).

Both Donabedian's and Reason's models of quality and safety form the foundations for the ICPS conceptual framework rather than sitting in opposition to or being replaced by it (Sherman, et al., 2009). Any changes or modifications to these models subsequently impact upon the construction of the ICPS conceptual framework. The authors of the ICPS conceptual framework recognise that as understanding of the determinants of healthcare processes and outcomes develop, the ICPS conceptual framework will develop and needs to "remain dynamic in the ever-changing world of healthcare" (Runciman, et al., 2010, p. 4). They specifically state that one such way of doing this is using qualitative research methods such as ethnography and discourse analysis, which will lead to a greater understanding of how the determinants of healthcare processes and outcomes develop.

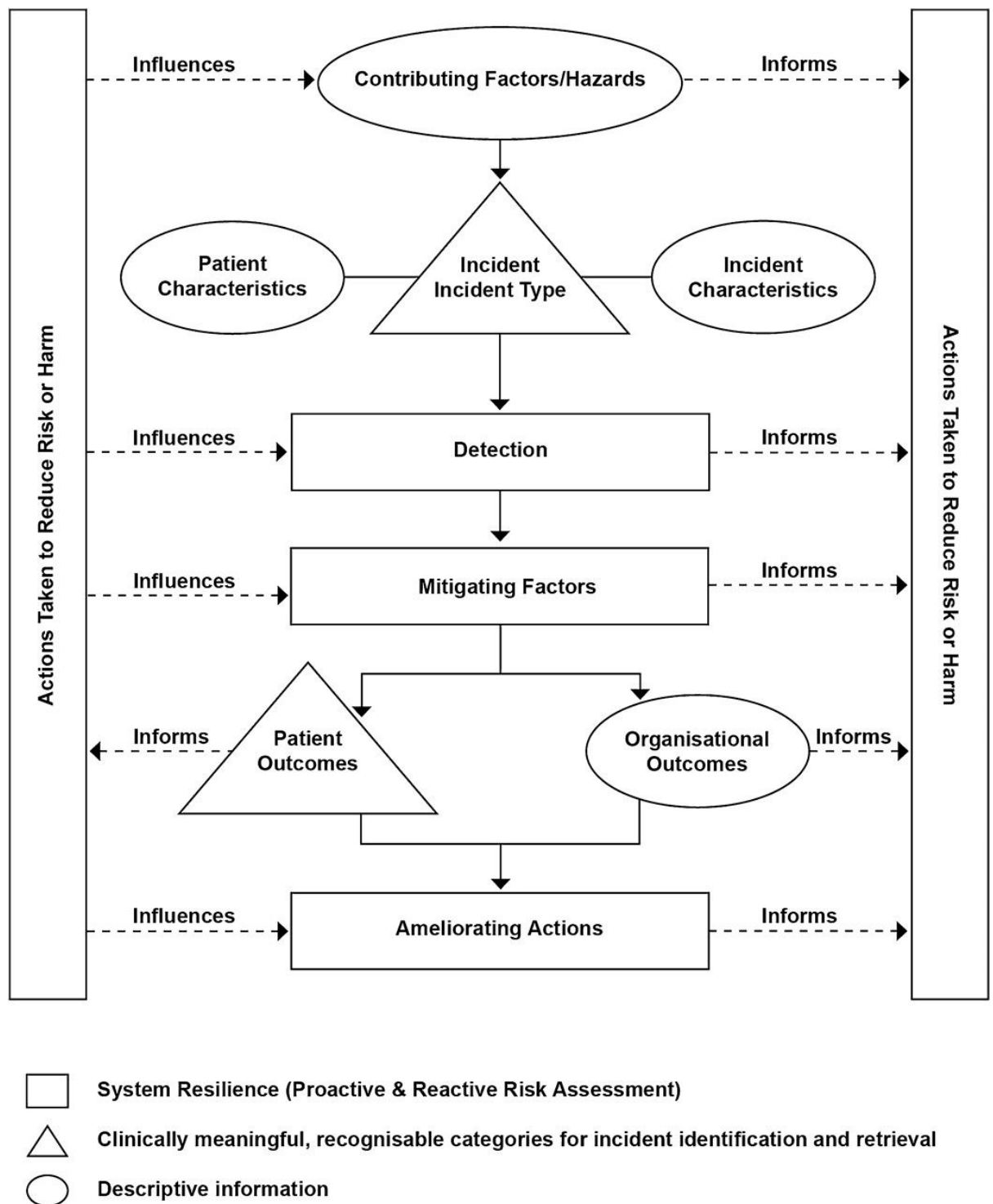


Figure 2.3: International Classification for Patient Safety conceptual framework. Reproduced from Sherman et al. (2009), International Journal for Quality in Healthcare, 21(1), by permission of Oxford University Press.

2.2.5 Identifying Patient Safety Incidents

In order to identify the active failures, latent conditions and resident pathogens that contribute to safety incidents, it is first necessary to identify when a patient safety incident occurs. This can be when all of the holes line up and an adverse event occurs, or in cases of near-misses, where a barrier performs its function and stops the patient from being harmed (Reason, 2000).

Consequently patient safety reporting is now a feature of all modern healthcare organisations, for example in the UK the NRLS collects confidential reports of patient safety incidents from healthcare professionals and organisations in the UK, which are then monitored. From these reports, trends and causes of incidents are identified, with patient safety alerts provided to relevant organisations so that they are able to change the systems in which the healthcare professionals operate. Prior to reforms to health and social care in the UK, the NRLS was operated by the NPSA, with responsibility for the system now resting with a sub-committee of the NHS Commissioning Board (Department of Health, 2010b).

The NRLS was constructed based on the systems approach to safety (Department of Health, 2000b), as can be seen through the use of confidential reports which ensure that no healthcare professionals or patients are identified, thus reinforcing that it is not a system of blame. The first pilot of the NRLS resulted in problems with the data quality received and the technical implementation of the reporting system (Williams & Osborn, 2006). As a result, Williams and Osborn (2006) report that the NRLS became a bespoke system, which they identify as being essential in the development of a reporting system. Other lessons included emphasising a safety culture through the development of supporting tools such as root-cause analysis training, implementing a learning and dissemination strategy alongside the reporting system, developing a strategy to promote new safety interventions and considering how to encourage compliance from front line healthcare professionals (Williams & Osborn, 2006).

The implementation of the NRLS has been associated with a change in organisational culture, with Hutchinson et al. (2009) finding that the longer acute hospitals were connected to the NRLS, the number of incidents that they reported increased, whilst at the same time their cultures were more orientated towards patient safety.

However hospital reporting systems have received criticism as they are unable to identify as many safety incidents as other methods of incident identification, such as retrospective record reviews. Christiaans-Dingelhoff et al. (2011) compared retrospective record reviews

with informal and formal patient complaints, patient litigation and healthcare professional incident reports and found that only 3.6% of incidents identified by the retrospective record review were reported using the other mechanisms. Additionally, the severity ratings of medication errors often differ between time points and different professions (Williams & Ashcroft, 2009), which may suggest similar reporting differences also occur in other incident types.

Although this suggests that the record review is the most comprehensive method of identifying safety incidents, it does have drawbacks. The main limitation is that it is expensive and time-consuming, requiring specially trained healthcare professionals to systematically search through the records of each patient (Woloshynowych, Neale, & Vincent, 2003).

2.2.6 Process of Learning from Patient Safety Incidents

Despite the limitations in the current methods of incident identification, they still act as a viable means of organisational learning. As awareness of patient safety issues continues to increase on both a national and local level, there are an increasing number of initiatives that aim to increase organisational learning around patient safety.

Information collated from the NRLS and analysed by the NPSA is disseminated to NHS organisations in the form of patient safety alerts. These aim to increase awareness of common incidents that are being reported to the NRLS on a national scale, meaning that even if individual organisations are unaware there is a safety issue, they can still implement the changes and make their patients safer. Benn, Koutantji, et al. (2009) examined the processes for providing feedback to local organisations from incident reporting systems and identified the need for it to consist of a multiplicity of methods. These include providing broad information dissemination and multiple methods of feedback which will both raise awareness of issues most pertinent to frontline staff, further promote a patient safety culture and consequently encourage future reporting.

A further method of organisational development is through educational sessions aimed to improve skills of various healthcare professionals and managers to fully explore patient safety incidents. For example the NPSA ran training sessions on root cause analysis, a retrospective method of exploring the origin of a patient safety incident. In particular it is a technique that is recognised as being aligned with the systems approach to safety in determining the active failures and latent conditions associated with an incident. An

evaluation of the programme (Wallace, et al., 2009) established that it enhanced knowledge amongst participants, although it was also highlighted that continued education is required in order for the participants to achieve a more consistent level of competency amongst participants.

In addition to learning from patient safety incident reports, other factors need to be considered in relation to how organisations can learn about patient safety. Leape et al. (2009) identified five concepts that are essential to improving safety within healthcare organisations, which focus on integration of care services across boundaries, patient involvement, transparency, the restoration of joy and meaning in work for healthcare professionals and a reform to medical education.

It is in relation to the first two of these concepts, the integration of care services across boundaries and patient involvement that the present study is situated, where the identification and reporting of patient safety incidents by patients themselves can arguably help to make organisational care transfers safer.

2.2.7 Initiatives to Improve Safety in the North East of England

Whilst on a national and international level there are a number of patient safety initiatives, such as reducing the number of venous thromboembolism occurrences and the number of wrong-site surgeries, there is also a need for local initiatives that aim to address local variations that occur in patient safety (Andermann, et al., 2011).

On a local level, the North East SHA released a Patient Safety Strategic Framework (NHS North East, 2008) which provided a focus on specific clinical safety themes. These themes related closely to the major types of patient safety incidents and include 'Managing the Deteriorating Patient', 'Drug Safety Issues', 'Healthcare Associated Infections', 'Suicide', 'Safe Surgical Procedures', 'Care Transfers, Handovers and Discharges (Inter-Disciplinary and Inter-Agency Working)', 'Falls', 'Review of Outlying Mortality Rates for Conditions and Procedures to Identify Priorities for Action' and 'Safeguarding'.

The framework recognised that these themes originated from a number of sources, such as local intelligence from serious untoward incidents (SUIs), local data from the NRLS, safety priorities of individual trusts and on a national level, evidence based guidance and feedback from clinicians and managers. The themes spanned a number of different organisations depending on their relevance, such as acute hospitals, mental health and primary care. For

each of the themes responsibility lies with the Patient Safety Action Team (PSAT), who have developed a number of internal 'Objectives, Goals, Initiatives and Measures' (OGIMs) that aim to give direction to the individual themes.

It is within this Patient Safety Strategic Framework that the present research is positioned. The North East SHA sponsored this research with a specific focus on patient perceptions and reporting of safety under the theme of 'Care Transfers, Handovers and Discharges (Inter-Disciplinary and Inter-Agency Working)'. An overview of this theme is provided in the next section, outlining the important patient safety issues that are related to organisational care transfers, including the types, identification and current reporting of incidents.

2.3 Care Transfers, Handovers and Discharges (Inter-Disciplinary and Inter-Agency Working)

The overall objective of the care transfers theme was to ‘achieve a demonstrable improvement in the safety and quality of the patient experience in relation to care transfers’ (internal OGIM). Within this objective, there are a number of goals, initiatives and measures. Although not all relate to the present study, the ones that do are reported in Table 2.4.

Goals	Initiatives	Measures
Identify the core mandatory information required for effective onward patient referral to ensure safe and effective practice and to develop an assurance framework to support care transfers	Recognition of existing good practice Identification of specific service improvements required	Patient stories about good/bad experience in relation to information supporting their care transfer

Table 2.4: Goals, Initiatives and Measures from the Care Transfers OGIM of relevance to this study.

The majority of research projects and governmental policy focus on safety within secondary healthcare organisations, such as in ‘An organisation with a memory’ (Department of Health, 2000b). However healthcare is a series of complex interactions between many different organisations. More specifically, complex systems have been defined as “a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent’s actions changes the context for other agents” (Plsek & Greenhalgh, 2001, p. 625). This complexity is further complicated by the unclear boundaries that exist in healthcare, such as professional roles and organisational responsibilities for patients. Within these complex systems there are many boundaries that patients will have to traverse during an episode of healthcare. Cook et al. (2000) identified that these transitions are particularly high in risk as the patient has to cross organisational and institutional boundaries, including commissioning and funding boundaries, which means moving between different professional roles, responsibilities and power. This increases the opportunities for active failures to occur.

Organisational care transfers are an area of healthcare where many terms can be used to refer to similar processes. For example it is plausible to use the simple definition that every time a patient is transferred from one service to another, they are undertaking a care transfer. However from this definition it is unclear whether the patient is physically being

transferred from one provider to another, from one ward to another or their care is being transferred from one team to another but remain in the same physical location. Table 2.5 provides a definition of the terms that were developed for the purpose of this study in relation to organisational care transfers.

Term	Definition
<i>Organisational Care Transfer / Care Transfer</i>	The transfer of a patient from one setting to another, where either or both the organisations are healthcare providers. This includes the Arrival (Admission), Journey and Departure (Discharge) stages of the transfer.
<i>Handover</i>	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.
<i>Departure (Discharge)</i>	The process by which a patient leaves their current location. If this is a healthcare provider, the departure is called a discharge.
<i>Arrival (Admission)</i>	The point at which a patient enters a location. If this is a healthcare provider, the arrival is called an admission.
<i>Journey</i>	The physical movement of a patient from one location to another, where at least one of the locations is a healthcare setting.

Table 2.5: Definitions relating to care transfers used throughout this study.

2.3.1 Number of Patient Safety Incidents in Organisational Care Transfers

Care transfers have been highlighted to be high in risk, in particular inpatient-outpatient transitions (Arora & Farnan, 2008) and the care of patients post-discharge (Forster, et al., 2003). In a recent review of the literature, the incident rate of adverse events in care transfers has been estimated to be around 20% (Tsilimingras & Bates, 2008), in comparison to the regularly accepted healthcare average of around 10% in other care settings.

Despite these explorations of incident rates, the number of incidents reported around care transfers in the North East of England has been far lower. The North East Ambulance Service (NEAS) provides healthcare transport to regional counties including Northumberland, Tyne and Wear, Durham and Teesside, serving a population of approximately 2.6 million people (North East Ambulance Service, 2011). Despite responding

to more than 900 emergency calls a day and transporting more than 4000 patients a day (North East Ambulance Service, 2011), NEAS have a very low reported incidence rate of adverse events. The NPSA release bi-yearly figures for the number of safety incidents reported to the NRLS by each NHS organisation; for the period of 1st April 2010 to 30th September 2010, NEAS only reported 5 incidents over the space of 3 months. These five incidents are presented in Table 2.6 alongside the UK average for all Ambulance Trusts over the space of six months.

Incident Category	NEAS (% unavailable)	UK Average for Ambulance Trusts
<i>Access, admission, transfer, discharge (including missing patient)</i>	1	56.8
<i>Clinical assessment (including diagnosis, scans, tests, assessments)</i>	0	5.9
<i>Consent, communication, confidentiality</i>	0	13.5
<i>Disruptive, aggressive behaviour</i>	0	8.3
<i>Implementation of care and ongoing monitoring / review</i>	0	6.2
<i>Infrastructure (including staffing, facilities, environment)</i>	0	9.8
<i>Medical device / equipment</i>	0	20
<i>Medication</i>	0	7.8
<i>Patient accident</i>	3	40.3
<i>Treatment, procedure</i>	0	14.8
<i>All other categories</i>	1	15.2

Table 2.6: Incident classifications and rates of patient safety incidents reported to the NRLS by NEAS and the UK average from 1st April 2010 to 30th September 2010 (NPSA, 2011c).

The NRLS also provides reports on the number of incidents occurring in relation to 'access, admission, transfer and discharge (including missing patient)' for all NHS Trusts. As a percentage of all incidents reported, these only comprise 8% (where data is available), suggesting that not all incidents are currently identified in care transfers. The numbers of incidents in this category for local NHS Trusts (excluding Ambulance) are presented in Table 2.7.

NHS Trust	Number of Incidents (%)	Period of Months
<i>County Durham PCT</i>	14 (5.3)	6
<i>Darlington PCT</i>	8 (2.97)	1
<i>Gateshead PCT</i>	22 (11.76)	6
<i>Hartlepool PCT</i>	5 (no data available)	1
<i>Middlesbrough PCT</i>	4 (no data available)	1
<i>Northumberland Care Trust</i>	26 (10.7)	3
<i>South Tyneside PCT</i>	15 (6.02)	6
<i>Stockton-on-Tees Teaching PCT</i>	1 (no data available)	1
<i>Sunderland Teaching PCT</i>	30 (12.1)	6

Table 2.7: Number of incidents occurring during access, admission, transfer and discharge (including missing patients) from 1st April 2010 to 30th September 2010 (NPSA, 2011c).

The data collected by the NPSA was indicative only of the number of incidents reported by NHS Trusts, and did not necessarily factor in incidents occurring when patients are transferred to social care or private healthcare organisations. Similarly, it is likely that incidents occurring when patients are transferred by other means, such as taxis or private cars are not reported. Despite this, the number of reported incidents was considerably lower than would be expected based on previous research (i.e. Forster, et al., 2004; Forster, et al., 2003; Tsilimingras & Bates, 2008) and on other ambulance trusts, where the next lowest number of reported incidents are 56 over a period of 6 months. This is suggestive of a poor patient safety culture within NEAS in comparison to other ambulance trusts where reporting of incidents is either not encouraged or not viewed as a priority.

2.3.2 Different Categories of Journeys

Due to the disjointed and complex nature of healthcare, there are a number of different locations patients can be transferred to and from, such as primary and secondary care, private residences, nursing homes and social care homes. With the increasing emphasis of competition within healthcare in the UK and the move to CCGs that has been proposed with the Health and Social Care Bill, which at the time of writing is awaiting its second reading in the House of Lords, this is likely to increase the number of healthcare providers as private organisations begin to play a bigger role in the provision of healthcare. As the number of providers increase, it is possible that the numbers of transfers between them are also likely to increase resulting in a greater requirement for safer care during these transfers.

Cwinn et al. (2009) identified that there is a gap in the literature that focused on the safety of organisational care transfers between nursing homes and acute care and found that information gaps occurred in 85.5% of all cases that they studied. This is considerably higher than other reports of handovers; however it is perhaps indicative of crossing different types of organisational boundaries where information gaps may not be classified as a patient safety incident, providers may have different requirements and standards for information or due to the use of incompatible systems. Nonetheless, it emphasises the complexity of healthcare and the need for a greater exploration of safety incidents within organisational care transfers.

2.3.3 Types of Adverse Events in Organisational Care Transfers

There are a number of different types of patient safety incidents that occur during organisational care transfers. However the number of studies exploring these have been minimal, and as such there is scope for a wider range of adverse events to be identified, including those that may not have been identified within acute or primary care settings. The NPSA, when reporting the number of safety incidents in Ambulance Trusts use the same classification of incidents as all other healthcare settings such as acute settings (Table 2.6).

The types of incidents reported by to the NRLS differ significantly to those found using other methods of incident identification that are frequently used in research, such as retrospective record reviews, telephone interviews and prospective observations. The incidents identified in the literature often relate to one specific stage of the transfer, such as admission or discharge, and in few cases the journey itself. For this reason the incident rates are not comparable between those reported to the NRLS and those reported in the literature. Naessens et al. (2009) came to a similar conclusion when comparing patient safety indicators, provider-reported events and global trigger tool findings, stating that the number and types of adverse events reported differed depending on the method of detection.

It is thought that the majority of post-discharge adverse events are due to medication errors (Forster, et al., 2004; Forster, et al., 2003), although they are also common during the admission process (Tam, et al., 2005). During admission to hospital medication reconciliations are often conducted if any changes are needed to the patient's medication. Aronson (2009) identifies four types of medication error that can occur during the prescribing stage; knowledge-based errors, action-based errors, memory-based errors and rule-based errors. The former three of these are active failures, whereas the latter is a latent failure, as defined by the Swiss-Cheese model of safety (Reason, 2000).

Any error made during admission is likely to impact upon the patient both during their stay and post-discharge unless any mistakes are addressed accurately in the discharge summary. Perren et al. (2009) identified that omitted and unjustified medications are a major cause of safety incidents during the discharge process, suggesting that when mistakes have been made they are not addressed at a later time, resulting in longer-lasting harm.

A lack of adherence with medication further affects the safety of a patient, including increased mortality and relapses of disease symptoms (Lehane & McCarthy, 2009). Medication safety is particularly pertinent to elderly people being discharged from hospital as they are likely to be on numerous medications. Despite this, elderly service users have been reported to be dissatisfied with the management of medicines on discharge from hospital (Knight, et al., 2011).

Due to the nature of organisational care transfers often revolving around either moving the patient or the patient moving themselves, falls are another major source of adverse events, particularly in the elderly (Tsilimingras, Brummel-Smith, & Brooks, 2009). There have been a considerable number of studies exploring the incident rates of falls in hospitals and interventions to reduce them, however there have been far fewer studies exploring this issue during organisational care transfers. Forster et al. (2004; 2003) found that post-discharge falls account for between 2-4% of adverse events, whilst Davenport et al. (2009) found that patients who fall whilst in hospital are at a high risk of falls post-discharge. Within the North East of England, reducing the number of falls in the community, which naturally includes patients post-discharge, can have both financial and operational benefits for the local ambulance service (Newton, et al., 2006).

Linked to falls are adverse events surrounding the use of ambulance stretchers during patient transfers which can lead to severe harm to the patient or even death (Wang, et al., 2009). Comprehensive data on the number of falls that occur during transfers is currently unavailable, although the study by Wang et al. (2009) highlight that the issue is of importance.

The third most common patient safety incident identified by Forster et al. (2004) are healthcare acquired infections. These can take many different forms and occur in all areas of healthcare, though the most common are predominantly hospital-based such as gastrointestinal, urinary tract and surgical site infections (Smyth, et al., 2008). Because of this, it can be suggested that the majority of instances of healthcare acquired infections

arising during the care transfer occur during the normal process of care but are then missed during handover, whether on admission or discharge, or present themselves post-discharge.

2.3.4 Causes and Impact of Patient Safety Incidents in Organisational Care Transfers

As with all types of adverse events, both latent conditions and active failures can lead to patient safety incidents occurring within organisational care transfers. The difference is that when patients are going through a care transfer, there are often more and different types of hazards than in other care settings, such as the process of medication reconciliation, the transfer of patient information and the physical movement of often fragile patients. There are also more gaps present in organisational care transfers (Cook, Render, & Woods, 2000) meaning that it is easier for the defences, barriers and safeguards to line up, which consequently leads to an increased number of hazards reaching the patient.

There is a limited amount of research exploring the causes of adverse events in organisational care transfers, however one cause that is regularly highlighted is the inconsistent transfer of patient information during the hand-off and handover processes and a lack of communication between healthcare providers and professionals (Arora & Farnan, 2008; Hains, et al., 2011; Kripalani, et al., 2007; Ye, et al., 2007).

Hains et al. (2011) explored what impacted upon the quality and safety of patients during non-emergency transport and generated three key components; communication, efficiency and appropriateness. Communication encompasses telephone calls to arrange transfers, documentation of patient information and standardised protocols for the transfer of the patient. Efficiency focuses on time delays and poor resources, whilst appropriateness centres on the necessity of transport, personnel, equipment, method of transport and education. Furthermore, Hains et al. (2011) highlighted that patient outcomes in relation to quality and safety in care transfers are rarely measured, implying that the outcome of an adverse event occurring during the transfer is often unknown.

Where patient outcomes have been explored, it has been suggested that patient safety incidents impact upon how patients perceive their continuity of care and the trust that they place in the healthcare system. Kripalani et al. (2007) highlighted that poor communication between hospital-based and primary care physicians had a negative effect on the continuity of patient care. Gulliford et al. (2006) define continuity of care as either a continuous relationship with an individual healthcare professional or a seamless service embedded within a multi-disciplinary team. The latter applies to organisational care transfers, and

engages both patient perspectives, such as satisfaction, and service delivery from the provider perspective.

Furthermore, low continuity of care is associated with lower levels of trust in healthcare professionals, which can impact upon the quality and outcomes of care (Mainous, et al., 2001). The role of trust is further explored in relation to how patients perceive their own safety by Pandhi et al. (2008) who found that in older patients, those who have continuity of care felt safer. With regards to iatrogenic illnesses, Entwistle and Quick (2006) identified that patients are able to identify safety incidents without always affecting the trust that they have in their healthcare providers; depending on the severity and nature of the incident. Likewise, patients participating in their own safety is not likely to weaken the trust that they have in their healthcare providers (Schwappach & Wernli, 2010).

2.3.5 Efforts to Improve the Safety of Organisational Care Transfers

Few efforts have been made to reduce the number of safety incidents occurring during care transfers. They predominantly focus on improving the transfer of information and communication between healthcare professionals. Boockvar et al. (2010) found that the use of electronic health records to improve information transfer proved to be unsuccessful with the same number of medication safety incidents occurring as when paper health records were used. This is suggestive of there being a need for an alternative method of reducing patient safety incidents within healthcare services around the time of an organisational care transfer. For example medication reconciliation can be improved through employing dedicated staff and reducing the reliance on computerised systems (Boockvar, et al., 2010).

2.3.6 Demographics of Patients Being Transferred

Within the North East of England most care transfers are conducted by the Patient Transport Service (PTS) branch of NEAS (NEAS, 2011), where patients are predominantly older people that may be frail (Department of Health, 1998). Consequently the incident rates and types of adverse events differ considerably to younger patients (Rowell, et al., 2010), and it has also been identified that older patients are more likely to experience an adverse event post-discharge than other age groups, a result of discontinuity of care (Tsilimingras, Brummel-Smith, & Brooks, 2009).

Inefficient communication between healthcare professionals has been identified to affect the safety of older patients during care transfers (Cwinn, et al., 2009), however Hastings et al.

(2011) found older people may not understand discharge information due to poor communication strategies, potentially impacting upon their safety.

The Parliamentary and Health Services Ombudsman (2011) has recently reported on the care of ten older people receiving care in the NHS and identified that there is a “gulf between the principles and values of the NHS Constitution and the felt reality of being an older person in the care of the NHS in England” (p.7). The report also highlights that the care of older people focuses predominantly on resolving the clinical condition rather than providing a compassionate and considerate service that responds to the social and emotional needs of the patient and their families.

2.3.7 Dominance of the Medical Model in Patient Safety

This same dominance of the medical model which focuses on clinical outcomes can also be seen within the field of patient safety. In particular the current definitions of what is classed as a patient safety incident, whether in the literature or policy, focus predominantly on the clinical definitions of safety, often excluding the way that patients view safety.

In addition, healthcare services rely predominantly upon healthcare professionals to identify and report safety incidents, whether through the NRLS or other means such as trigger tools and record reviews. As these methods are based upon healthcare professional definitions of safety and utilise quantitative methods of analysis to identify safety incidents, they may reduce the role of patients being involved in their own safety. Ocloo (2010) suggests that this dominance of the medical profession helps to construct patient harm further through concealing social processes such as power, especially when positioned within a blame culture that conceals incidents.

Health services throughout the world are becoming more aware of the requirement for patients to become more involved in their healthcare, which will in turn reduce the dominant model currently in place. The next section of this chapter will discuss patient and public involvement in healthcare with a focus on how patients can become involved in their own safety.

2.4 Patient and Public Involvement

There is an increasing emphasis for patients and the public to contribute to their healthcare, including the planning, development and more recently the commissioning of services. There are a number of different terminologies that can be used when discussing involvement, such as empowerment, engagement and representation. These are representative of consumerism and participatory democracy; polar opposites on the continuum of patient and public involvement. According to the continuum, consumerism places the patient as a consumer in a neo-liberal setting that is deserving of satisfaction through services responding to their needs, whilst participatory democracy places the emphasis upon citizen rights to shape the services that they receive (Kreindler, 2009).

Current patient and public involvement (PPI) policy displays both neo-liberalist and participatory democratic features. Both of these developed through different approaches to PPI, with a consumerist approach linked with neo-liberalism adopted by a Conservative government wanting to increase efficiency in the early 1990s, and further developed by the following Labour government in 1997 to emphasise quality through the inclusion of participatory democratic traits in policy (Gibson, Britten, & Lynch, 2012).

One central theme of neo-liberalism; placing a greater emphasis upon market forces and the role of the consumer (Heywood, 2012) is evident within reforms to health and social care introduced in 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010a) where there is to be increased competition from private providers, and a greater emphasis placed upon patient satisfaction and experiences. The impact upon PPI is clear in the conversion of LINKs to HealthWatch England and local HealthWatch organisations, which are to be located in the Care Quality Commission and are proposed to promote choice and facilitate in complaints advocacy.

Despite this, the participatory democratic approach to PPI still exists in the form of service users being involved in the commissioning of healthcare services via clinical commissioning groups, which will be separated from the more apparent consumerist approaches. This separation is arguably a result of the two approaches forming on different ends of the continuum (Kreindler, 2009), and reduces the impact of democratic approaches upon healthcare delivery as it is still unclear how service users will be involved in the commissioning of services other than for their experiences to be measured in a consumerist fashion, using approaches to involvement synonymous with market research, such as satisfaction surveys (Vukmer, 2006).

Despite healthcare policy moving towards a more consumerist approach, for the purpose of this research PPI is used throughout to represent the participatory democratic nature of the research rather than as a consumerist tool.

The different roles that people play and the power issues that accompany these two approaches are discussed below in relation to the term PPI. However it is a combination of these issues and the policy context of PPI that frames its use throughout this study. In addition, involvement is seen as a none-threatening term to healthcare professionals, patients and the public (Shaw & Baker, 2004), where definitions of PPI are similar across these groups, and include respect, dialogue and shared decision making (Rise, et al., 2011).

2.4.1 Policy Context of Patient and Public Involvement

The NHS Plan (Department of Health, 2000a) outlined the need to improve the patient experience whilst at the same time making healthcare safer. Methods of involving patients and the public in healthcare decisions include a variety of mechanisms, such as patient choice over their healthcare provider, patient advocates (via the Patient Advice and Liaison Service; PALS) and Local Involvement Networks (LINKs). More recently the Department of Health (2009c) released a guide on patient and public engagement that specified three objectives: to provide world-class health and social care that is patient-centred, to use patient experience to improve healthcare quality and to engage and empower patients and the public. This has been further reinforced by the recent white paper Equity and Excellence: Liberating the NHS (Department of Health, 2010a), which despite the changes in healthcare commissioning still champions PPI and introduces the concept of 'nothing about me without me'.

The principles behind PPI are to move away from national initiatives and systems that drive choices, but instead focus on local initiatives that are guided by patients (Department of Health, 2004), which in turn makes local healthcare services more accountable to the people that they serve. Although healthcare organisations listening to patients is not a new process, with initiatives dating back to Local Voices (NHS Management Executive, 1992) and earlier, as reported by Florin & Dixon (2004), it has been deemed that there is room for further improvement (Department of Health, 2010a). The NHS Act 2006 also now makes patient and public involvement a statutory obligation for healthcare commissioners and providers, with patient and public engagement a key component of world class commissioning (Department of Health, 2007). With the release of The Health Act 2009, the NHS

Constitution (Department of Health, 2010c) came into force, which in relation to involvement grants two rights to patients;

- “the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this” (p. 10)
- “the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services” (p.11)

Despite such initiatives, government policies have regularly identified that although patients are often talked to, they are rarely listened to (Department of Health, 2000a), and there is a need to “move from a service that does things *to* and *for* patients to one that is patient-led, where the service works *with* patients to support them with their needs” (Department of Health, 2005, p. 3, emphasis authors' own). The Picker Institute (2007) found from 26 national patient surveys that patients are not involved in as many decisions as they wish to be. Perhaps a reason for this is that there is currently a limited amount of evidence either supporting or opposing PPI (Crawford, et al., 2002; Staniszewska, Herron-Marx, & Mockford, 2008).

2.4.2 The Evidence for Patient and Public Involvement in Healthcare

Several factors have contributed to the existence of only a small evidence base, including poor quality research, such as difficulties matching outcomes to PPI and the democratic and ethical nature of PPI, which is that because patients and the public fund the NHS, they deserve to be involved in the management of it (Crawford, et al., 2002; Staniszewska, Herron-Marx, & Mockford, 2008). However despite the lack of evidence, there is the potential for a number of outcomes relating to PPI in healthcare, including an improvement in accountability, service quality and service provision (Andersson, Tritter, & Wilson, 2006; Crawford, et al., 2002). In particular, patient reports of healthcare, such as satisfaction, can lead to significant changes in hospitals by acting as an incentive for change (Longo, et al., 1997; Riiskjær, et al., 2010).

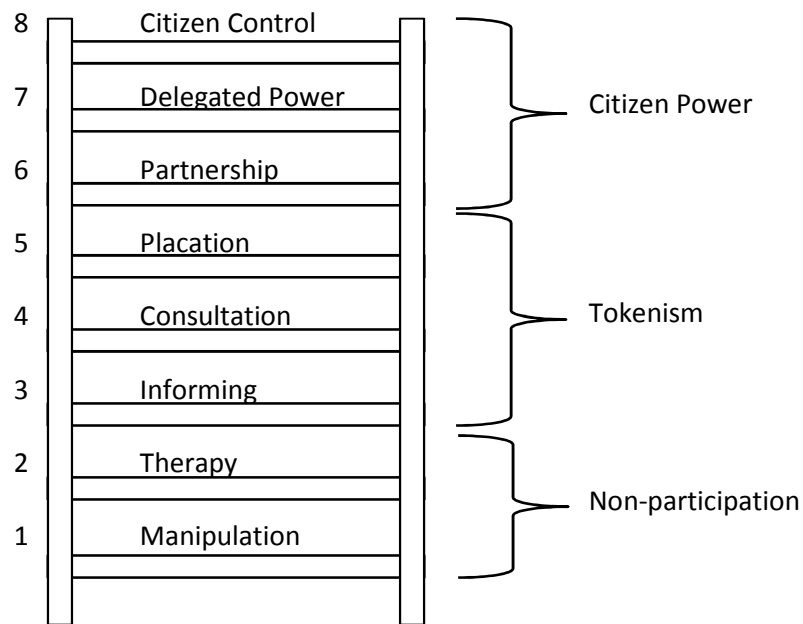


Figure 2.4: Ladder of citizen involvement (Arnstein, 1969).

Arnstein (1969) first proposed the ladder of citizen involvement which provides a hierarchal relationship between the different stages; moving from non-participation to certain degrees of tokenism and finally degrees of citizen (public) power. According to Arnstein's model of involvement, genuine involvement requires that power is transferred; in this instance from policy holders, healthcare professionals and managers to patients and the public. Tritter (2009) argues that as well as power affecting the levels of involvement, so does method and expectation. It is therefore necessary to create a balanced approach that incorporates each of these factors when planning user involvement. Furthermore Arnstein's model does not take into account the outcomes of user involvement, instead working on the assumption that with greater levels of power, the greater the outcomes (Tritter & McCallum, 2006).

By incorporating Arnstein's ladder of involvement into healthcare, it is possible to explore the current levels of involvement, and in turn how power has been devolved to patients and the public. However within healthcare, power is complicated as patients may not want to be involved depending upon their individual characteristics. These can be split into three categories; their need for healthcare (type of illness and seriousness), personal characteristics (knowledge / expertise and personality) and professional relationships (trust) (Thompson, 2007).

For those who do wish to be involved in their healthcare, there are not always mechanisms in place for them to do so. When there are mechanisms, they may not be able to cater for

everyone. For example involving people in commissioning and health research involves a relatively small number of patients, and as such decisions need to be made when deciding who to involve (Williamson, 2007).

2.4.3 Determining Who to Involve in Healthcare

As patients are not homogenous, but bring with them a wide range of demographics, conditions, knowledge and experience of healthcare, their perspectives naturally differ from one-another. Current healthcare policy aimed at increasing PPI is often vague and fails to expand upon any of these individual characteristics, which potentially results in certain 'types' of individual often being consulted or others being excluded. Therefore out of those that are willing to be involved in their healthcare, a clear approach to identifying which patients and members of the public to be involved is required.

Williamson (2007) identifies three types of knowledge and expertise that healthcare professionals attain in order to perform their functions; concrete (direct experience), theoretical (ideological and ethical) and a mixture of the two (subject specialism). Similar types of knowledge and experience exist within patients and the public, albeit not always at an individual level. Instead, Williamson (2007) suggests that they are spread throughout three different types of people. Individual patients often hold concrete knowledge, focused around their direct experiences of healthcare. Patient group members have a subject specialism, understanding and able to represent similar patients' views whilst having a broad knowledge of policies and practices. Finally, patient advocates or representatives possess the theoretical knowledge and often operate as professional patients, explaining the wider patient perspective but sometimes lacking in the concrete or subject specialism that other types of patients possess. Since patients, unlike healthcare professionals, do not often hold all three types of knowledge, all three types of the patient should be involved in healthcare so as to obtain as wide a perspective as possible.

2.4.3.1 Expert Patients

A further form of PPI in healthcare is expert patients, who are now widely recognised by healthcare professionals as being specialists in their own conditions (Donaldson, 2003). Anybody can be classed as an expert patient as long as they hold both concrete and theoretical knowledge about their care, thus developing a subject specialism. The benefits of being acknowledged as an expert patient are an improvement in self-efficacy and the encouragement to take an active role in their healthcare (Donaldson, 2003), whilst at the same it can change the balance of power in favour of the patient.

2.4.3.2 Patient Safety Champions

In addition to expert patients, the Department of Health (2006) highlighted the need for patients and the public to become patient safety champions to help to improve healthcare services by shaping them to the requirements of patients. In the UK, the charity Action against Medical Accidents (AvMA) partnered with the NPSA to develop a network of patient safety champions that were aligned to the SHAs. As such, the champions represent patient views from the local area on a national scale and likewise provide feedback from national meetings of champions to the PSAT in the NESHA and to patients within their own network, such as LINKs and the Patient, Carer and Public Engagement network. These champions are often classed as expert patients, but are then trained further in wider patient safety principles, meaning that they can provide similar input as patient safety experts into policy and practice, whilst at the same time still representing the patient perspective.

2.4.4 Patient and Public Involvement in Patient Safety

As has been identified, there is a clear justification for involving both patients and the public in their healthcare, and the network of patient safety champions is a move towards involving people in patient safety on a strategic level, as opposed to an individual level. This is evident regardless of where PPI is deemed to lie on the consumerism-participatory democracy continuum. Although this justification is clear, Vincent and Coulter (2002) highlighted the lack of patient involvement in patient safety as being remarkable given that the patient is the central component of all healthcare. This is still evident, although there has now been an increasing amount of research exploring what role the patient can have in their safety and the associated outcomes. It was Vincent and Coulter (2002) who outlined the original framework for patient involvement in safety, exploring how patients can become involved (Table 2.8).

Helping to reach an accurate diagnosis.
Deciding appropriate treatment and management strategy.
Choosing an experienced and safe provider.
Ensuring treatment is appropriately administered, monitored and adhered to.
Identifying side effects or adverse events and taking action.

Table 2.8: The patient’s role in promoting safety (Vincent & Coulter, 2002).

One possible reason for this lack of PPI in safety is that the majority of safety theories, models and cultures come from an engineering context, where there is no room for large variances in the product or outcome. Lyons (2007) provided a safety engineering (human

factors) perspective to PPI in safety, arguing that patients are able to act as a further barrier to preventing safety incidents from occurring, but that emphasis should still be placed on the technological systems.

An example of where patients can play a role in their safety is in the reduction of healthcare acquired infections. Hand-washing has long been established in reducing nosocomial infections (e.g. Barrett-Connor, 1972); however there is often a lack of adherence by healthcare professionals which require educational interventions (Harne-Britner, Allen, & Fowler, 2011). Studies exploring the role that patients can play have found that patients are willing to query if the healthcare professional has washed their hands (Bittle & LaMarche, 2009), which can result in increased hand-washing compliance (McGuckin, et al., 2001).

Furthermore, the NPSA (2006a) launched the Please Ask campaign which encourages PPI in all aspects of healthcare. However there is a particular emphasis on safety, promoting ten tips that patients can follow to ensure that they are safe. These include making healthcare professionals aware of any allergies, ask questions when uncertain, ensure staff have the correct personal information and to ask the healthcare professionals if they have washed their hands (NPSA, 2006b), although the latter of these introduces power issues between service users and healthcare professionals.

Despite it being important for there to be a reliance on the systems approach to safety, it is still argued that patient involvement can be effective in improving safety, as long as the burden or reliance of safety does not rest with the patient, but that they are a safety buffer created through interactions with safety-orientated healthcare professionals (Davis, et al., 2007). Leape et al. (2009) report that patient involvement ('nothing about me without me') is essential to providing safer care by introducing the patient, family members and carers as partners in their care. By becoming partners in their healthcare, patients can contribute to the construction of a shared understanding of patient safety (Hovey, et al., 2010) rather than being passive recipients in a medically dominated domain.

2.4.5 Current Mechanisms for Patients to Report Safety Incidents

Patient perspectives on the outcome of their care are starting to become increasingly considered, particularly within the NHS. Patient Reported Outcome Measures (PROMs) are now being used in the evaluation of healthcare outcomes to determine the quality of care provided from the patients' perspective. Devlin and Appleby (2010) state that PROMs offer enormous potential in areas of the NHS where data on quality is often poor or non-existent.

One such area is the reporting of patient safety incidents, especially within organisational care transfers where only 5 incidents have been reported in the North East of England (NPSA, 2011c).

Vincent and Coulter (2002) identified that patients can play a role in identifying safety incidents and subsequently taking action. Currently there are three processes by which patients can report safety incidents; informal discussions with staff members, making a formal complaint or making a patient safety report to the NPSA and litigation.

2.4.5.1 *Informal Feedback*

Patients are often inclined to speak up when they see something that concerns them regarding their healthcare. Entwistle et al. (2010) found that this willingness depended upon a number of factors, such as their perception of the severity of the incident and confidence about their grounds for concern, the perceived workloads and priorities of staff, and the impact that speaking up would have upon their healthcare. By speaking up about safety concerns, patients can improve their own safety and healthcare professionals can learn about being safer through the identification of active failures. However informal discussions do not lead to the resolution of latent conditions existing within healthcare organisations as root cause analysis cannot be performed where reports do not exist. Additionally, where there is a poor patient safety culture, healthcare professionals may perceive a patient questioning the safety of their clinical practice as an attempt to blame them and a threat to either their reputation or an impending litigation. In this circumstance, the healthcare professional is unlikely to learn from the incident.

2.4.5.2 *Patient Complaints*

The analysis of patient complaints can lead to organisational learning (Department of Health, 2009a; Jonsson & Ovretveit, 2008) through the identification of both active and latent failures. However patient complaints do not always give a reliable overview of safety as they can also relate to other aspects of healthcare quality, such as optimality and efficiency. In addition, only around 5% of people who are unhappy with their healthcare go on to make a complaint (National Audit Office, 2008), possibly due to patients often justifying why a problem had arisen in the first place (Hunt, et al., 2009). Healthcare literature (e.g. Sorensen, et al., 2010) and policy (NPSA, 2005) aims to reduce the number of complaints by apologising when something has gone wrong, although in an Australian setting this has been found to be unsuccessful as it does not meet the needs or expectations of the patient and family members (Iedema, et al., 2011). Reducing complaints can have a negative

impact upon the organisational learning that can occur from exploring complaints, however it can be assumed that in a safety orientated culture that the incident would instead be reported elsewhere, meaning that organisational learning can still occur.

If patients are unwilling to make a complaint about their healthcare, they can report a patient safety incident to the NRLS in a similar manner to healthcare professionals via an online form (NPSA, 2010b). This allows patients to provide data to be used alongside healthcare professional reports which can feed into patient safety alerts released by the NPSA. However this form of reporting is very scarce, perhaps due to patients being unaware of its existence and also that it is limited to online reporting only.

2.4.5.3 *Litigation*

The final form of action that a patient can take is through litigation, which is initiated through the NHS Litigation Authority (NHSLA). According to the NHSLA, 6,652 claims were made for clinical negligence in 2009/10, whilst 4,074 were made for non-clinical negligence (NHS Litigation Authority, 2010). As litigation usually only occurs when severe harm has been caused, the Department of Health (2000b) identified that it can be used for organisational learning from the most serious of incidents that are generally avoidable. The learning that can occur from litigation is often mirrored by patient complaints, as is demonstrated by Jonsson and Ovretveit (2008) and Christiaans-Dingelhoff et al. (2011).

2.4.6 *Issues Associated with Current Methods of Patient Reporting of Safety*

One of the greatest difficulties associated with how patients can report safety is how closely it is linked to patient satisfaction. Burroughs et al. (2005) found a strong link between patient-reported satisfaction and concerns over safety, whilst Kuzel et al. (2004) identified that by classifying emotional distress as a patient harm, the boundary between patient satisfaction and patient safety is blurred by the subjective perceptions individuals bring to the situation.

In addition to this blurred boundary, there are also discrepancies between patients when asked to be involved in their own safety depending upon the healthcare professional involved in their care. McGuckin et al. (2001) found that when evaluating a hand-washing campaign, patients were far more likely to ask nurses if they had washed their hands rather than physicians. Davis et al. (2007) identified five factors associated with patients becoming involved in their safety; patient-related, illness-related, healthcare professional-related, healthcare setting-related and task-related. These each relate closely to those identified by Thompson's (2007) dynamic dimensions of involvement but with a focus on patient safety.

Within the literature there also tends to be a negative focus on patient safety, with an overemphasis on what goes wrong in healthcare and methods that can be used to resolve issues. This is especially evident within patient reporting of safety, where King et al. (2010) identified that at the time of reviewing the literature (up until April 2008), all studies exploring patient reporting of safety focused on asking service users about being unsafe rather than safe.

2.4.7 Patient Perceptions of Safety

A fundamental issue related to patient reporting of safety incidents is that of the varied definitions of safety. It is becoming more widely recognised that patients define medical errors differently to healthcare professionals (Burroughs, et al., 2005; Burroughs, et al., 2007; Masso Guijarro, et al., 2010; Mazor, et al., 2010). More specifically, Burroughs et al. (2007) found that in the USA service users define medical errors to include falls, communication problems and responsiveness in addition to the clinical mistakes currently regarded as defining patient safety. This is further supported by Kuzel et al. (2004), who include emotional distress as a potential harm to a patient.

In addition to defining safety differently to healthcare professionals, Schwappach (2008) and Weissman et al. (2008) have both found that service users identify more than twice as many service user safety incidents than those found in clinical records, leaving potential for service users to play a role in reporting incidents, which is further supported by Coulter (2006). Evans et al. (2006) found that in Australia patient-reporting of incidents and medical records show similar levels of safety incidents. However it can be argued that although there are similar levels of incidents, they are different incidents being reported.

This is supported by Naessens et al. (2009) who suggest that different methods of incident identification can result in different incidents being detected. Evans et al. (2006) and Masso Guijarro et al. (2010) both suggest that service user reports of adverse events appear credible, giving further foundation for developing a service user mechanism for identifying and reporting adverse events.

2.4.8 Active Involvement of Patients in Reporting Safety Incidents

As has been identified, there are a number of issues regarding the current methods of reporting safety incidents. The most apparent of these is that there is still a blame culture within many areas of the healthcare service, whether this is within individual teams or across

organisations (Deilkas & Hofoss, 2010). This has an impact upon the number of incidents that are reported by healthcare professionals, which is evident in the number of incidents reported to the NRLS by NEAS. Further to this, it has been suggested that the systems approach to safety has not adequately reached frontline healthcare professionals (Waring, 2007).

Although the culture within NEAS has not been measured and reported, it is conceivable that from the number of incidents reported that a poor reporting culture and potentially a poor safety culture exists. To resolve the issue of poor reporting there are a number of methods organisations and regulatory bodies can implement, such as working to change organisational cultures and, as health services become more marketised, through the introduction of reporting targets to contracts.

An alternative to this is the active involvement of patients in the reporting of incidents, much in the same way that healthcare professionals can report incidents. Although healthcare organisations have the opportunity to learn from patient complaints, litigation and reports to the NRLS, each of these have considerable limitations. Instead, if healthcare organisations actively seek patient reports of safety it is possible that there will be greater potential for organisational learning, as they can provide a unique and exciting perspective (Pham, et al., 2010).

Friedman et al. (2008) explored patient identification and reporting of incidents in comparison to healthcare professionals and found that patients were likely to identify largely preventable adverse events, and those that were identified were often different to those that healthcare professionals report. Weissman et al. (2008) came to the same conclusion after comparing patient reports of safety with incidents found through medical record reviews.

The method of receiving the patient reports is more ambiguous, with King et al. (2010) identifying a lack of literature on methods to solicit patient reports of safety incidents, stating that from the evidence available, a mixture between closed- and open-ended questions is required which will allow for appropriate causal analysis and cater for patients who may not understand medical terminology.

2.5 Chapter Summary

Awareness of the need for patient safety is increasing throughout healthcare services in the UK, with reports stating that approximately 10% of people are harmed by the healthcare that

they receive. As a result, patient safety is now a central component of healthcare policy so as to provide safe, high quality care for all patients receiving care in the NHS.

This figure doubles in the context of organisational care transfers, where it has been estimated that patient safety incidents occur in approximately 20% of cases as a result of people falling through gaps in organisational boundaries. This emphasises the reason why there is a need for accurate reporting of patient safety incidents when people are having their care transferred, so that the healthcare systems in which healthcare professionals operate can be made safer through the identification of active failures and latent conditions.

In the North East of England, data on the number of incidents reported suggests that not all incidents are reported based on estimations, especially within NEAS where over a 3 month period, despite transporting more than 4000 patients a day, only 5 incidents were reported. Although this is only indicative of the journey stage of the transfer, excluding the admission (arrival) and discharge (departure) stages, it is still reflective of a poor patient safety culture, which has the potential to impact upon the safety of patients.

There are a number of approaches that can be taken to resolve this, such as transforming the patient safety culture or making reporting mandatory through commissioning. An alternative to this is to encourage patients to become involved in their own safety, which relates closely to the PPI initiative of working with patients rather than doing things to or for them. The evidence of patients' ability to identify and report safety incidents is increasing, however there has been no published research known to the researcher on patient reporting of safety within organisational care transfers, where patients are at an increased risk of iatrogenic harm.

By encouraging patients to report on their own safety, they can help to fill the holes left by current identification and reporting mechanisms, without having to go through complaints procedures or litigation. When this is considered in relation to the Swiss-Cheese and ICPS models of patient safety, it can be seen that patients can play a role in identifying the active failures and latent conditions that lead to safety incidents occurring. Within the ICPS model, patients can provide information alongside healthcare professionals that is relevant to the central components of learning from patient safety incidents and preventing them from happening again; prevention, error recovery and resilience.

The detection of incidents is essential to improving the systems that dictate how safe care is, and informal discussions with healthcare professionals do not provide a platform for organisational learning.

Service users have also been found to define safety differently to healthcare professionals, including emotional harm, communication and responsiveness on top of clinical definitions of safety. In addition to this, current studies exploring service user reporting of safety tend to focus on unsafe opposed to safe care.

2.6 Aims and Objectives

The aims of the research were to investigate service user perceptions of safety and to develop a method of facilitating service users to identify and report self-defined patient safety incidents in a care transfer setting, as defined by the Patient Safety Strategic Framework (NHS North East, 2008). More specifically, the objectives were to:

- Explore the concepts, explanations and terms used by service users when talking about safety in organisational care transfers.
- Explore what safe care feels like to service users in organisational care transfers.
- Define patient safety in organisational care transfers from service users' perspectives.
- Create a reporting mechanism that would facilitate service users to report on their self-defined safety when going through an organisational care transfer.

Chapter 3: Methodology

3.1 Chapter Overview

This chapter will restate the research aims and objectives and give an overview of the Appreciative Inquiry (AI) and Action Research (AR) methodologies that were combined within this study. Encapsulated are the philosophical underpinnings of the research, particularly in relation to Giddens' structuration theory and Bhaskar's critical realism as epistemological and ontological frameworks respectively. In particular patient perceptions and reporting of safety are contextualised philosophically alongside healthcare professional definitions of safety. These are then discussed in relation to how knowledge and structures fit within critical realism to create the world(s) that service users inhabit. Finally in relation to the philosophical underpinnings, the research participants and organisations are described in relation to how they relate to this study.

3.2 Research Aim

The aims of the research were to investigate service user perceptions of safety and to develop a method of facilitating service users to identify and report self-defined patient safety incidents in a care transfer setting, as defined by the Patient Safety Strategic Framework (NHS North East, 2008). To achieve these aims, the research was structured into two interlinked phases with mutually reinforcing methodologies.

3.3 Research Objectives

To achieve the aims, the study was split into two phases. The particular objectives of each phase are outlined below.

Phase 1

- Explore the concepts, explanations and terms used by service users when talking about safety in organisational care transfers,
- Explore what safe care feels like to service users in organisational care transfers,
- Define patient safety in organisational care transfers from service users' perspectives,

Phase 2

- Create a reporting mechanism that would facilitate service users to report on their self-defined safety when going through an organisational care transfer.

3.4 Research Philosophy

For any piece of research it is important to identify the philosophical assumptions of the study so as to make the research process and methodological choices more transparent. This section provides an overview of the ontological and epistemological frameworks that underpin the methodological approaches utilised, followed by their specific application to this study.

3.4.1 Ontological Framework

The ontological assumption of the research that provided a framework for the methodological choices was one of critical realism. This philosophical paradigm is based heavily upon Roy Bhaskar's work on transcendental realism, which was later termed critical realism. Put simply, critical realism states that "what we are studying determines the knowledge we can have of it" (Craib, 1984), which introduces the notion of interpretivism into the more traditional realist approaches to science. This is a very simplistic notion of critical realism, and the following section explores to a greater depth how these traditionally separate paradigms of interpretivism and realism intertwine.

Critical realism follows the ontological assumption of realism in that there is a single reality independent of those observing it that is knowable and thus changeable as far as knowledge allows. According to realism, this reality is only knowable through objective observations, removing any subjectivity that a researcher may bring to the situation. However where critical realism differs from realism is that it acknowledges surface phenomena are potentially misleading as to their true, underlying character. This is where within critical realism the interpretive nature of science emerges, as it argues that this subjectivity brings with it different perspectives and viewpoints of the given reality. Bhaskar labels the interpretivist nature of science the transitive dimension, whilst the realist nature is termed the intransitive. These titles are suggestive of the levels of fluctuation and disparities that can occur within each. It is here in this study that patient perceptions of safety are identified as potentially different to those of healthcare professionals, where each has a different perspective and viewpoint of safety.

According to Benton and Craib (2001), these points make critical realism fallible as the "critical realist insistence on the independent reality of the objects of our knowledge, and the necessity of work to overcome misleading appearances, implies that current beliefs will always be open to correction in the light of further cognitive work" (p.121). This fallibility can paradoxically be argued to be a strength of critical realism as a philosophical paradigm

because it allows for both interpretivist and realist approaches to research, with each bringing their own advantages depending upon the situation. This central position along the interpretivism / realism continuum allows for a mixed methods approach to research by employing qualitative methods to uncover the surface phenomena that may be hiding the underlying truth, and once uncovered using quantitative methods in the identification of clear and consistent patterns of practice (McEvoy & Richards, 2006).

When this ontological dualism was applied to this study, it was valuable to first uncover the 'underlying truth' of what safety means to patients when undergoing an organisational care transfer, and once uncovered, to use quantitative methods to identify the clear and consistent patterns of practice. This forms the basis for a greater understanding of the transitive nature of safety within organisational care transfers, which in turn can lead to a greater understanding of the intransitive dimensions of safety.

Within healthcare, safety is usually understood in one of two ways; (1) as something that is observable and immediately controllable, within a realist framework, or (2) as something that is constructed through social interactions, within an interpretivist framework. It is within (1) that the majority of literature on safety within healthcare sits, looking at risk management and the avoidance of error, representative of the intransitive nature of reality. It is for this reason that the majority of patient safety work focuses on measuring the number of incidents and reducing them through changes in practices and the environment. However Rochlin (1999) proposes that safety is an interactive, dynamic and communicative act, which is necessary for the construction and maintenance of safe operations. This means that the reductionist approaches to safety associated with the realist framework that do not factor in these contributory processes are at risk of oversimplifying problems and are thus vulnerable to disruption or distortion (Rochlin, 1999).

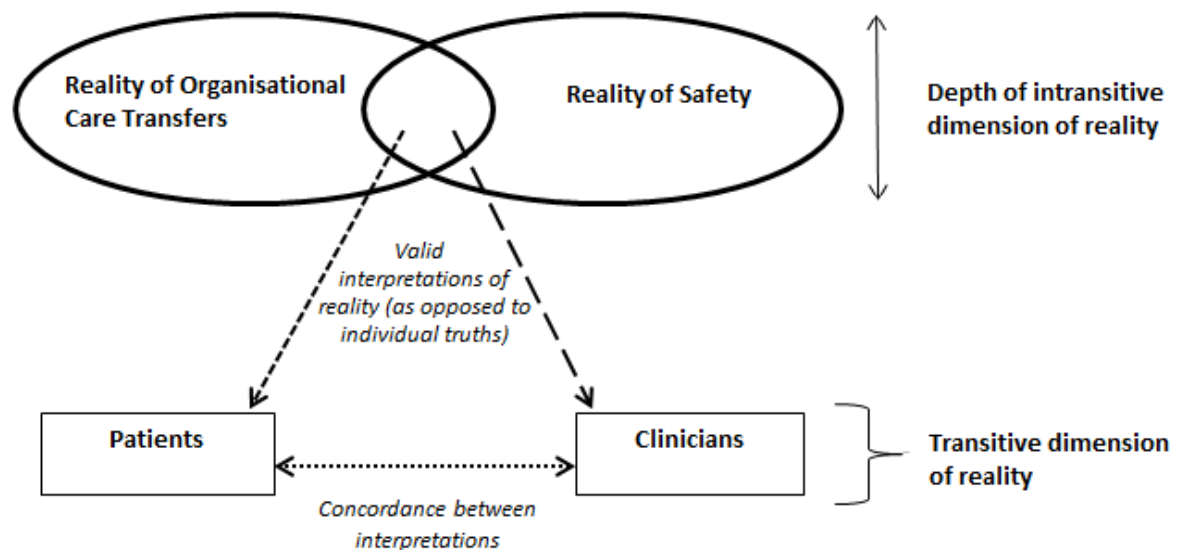


Figure 3.1: A diagrammatical representation of how reality is interpreted differently by patients and healthcare professionals within critical realism.

It is therefore arguable that a critical realist approach, based upon transitive and intransitive dimensions of safety can be applicable to this study by combining the constructed nature of safety with the observable. This can be seen in Figure 3.1, which demonstrates the transitive and intransitive nature of safety. In particular, the understanding of patient perceptions of safety are of importance when the patient is seen as being central to their healthcare. Without understanding how patients perceive safety, it is possible that any interventions aimed at improving safety may be vulnerable to disruption or distortion as highlighted by Rochlin (1999). Because the actor, in this case the patient, constructs their own interpretation of reality, then if the patient feels unsafe, they must therefore be unsafe.

3.4.2 Epistemology, Structure and Agency

In addition to the ontological assumptions of the study, it is also important to highlight the epistemological framework that underpins the study. As has been suggested within the transitive nature of reality, it can be argued that individual actors construct the reality (or the structures) in which they operate. This section will give an overview of how structures and agents are constructed and operate within a critical realist paradigm, along with how knowledge can be constructed.

Bourdieu discusses the differences in *phenomenological knowledge* and *objective knowledge*, where phenomenological knowledge is created through the construction of and reconstruction of subjective and intersubjective meanings and experiences, whilst objective

knowledge is created from an outsider's perspective which presents a view of the research object not accessible to itself.

According to Bourdieu, these form part of a hierarchy where phenomenological knowledge holds no scientific value, but objective knowledge risks hypostatizing itself as reality (Harrits, 2011). This supplements the critical realist approach where truly objective knowledge can be seen as a fallacy and instead represents different interpretations of reality.

This then poses the epistemological question of how knowledge is created within an AI and AR methodological approach that is underpinned by critical realism. Instead of knowledge being split into the two categories of phenomenological and objective as proposed by Bourdieu, knowledge is created within a critical realist paradigm through the amalgamation and the concordance between the phenomenological and objective knowledge that each participant, co-researcher or researcher brings together through social interactions and constructions. These social constructions form the epistemological relativism that underpins the transitive nature of science that critical realism claims to combine with the ontological realism.

A further epistemological issue that arises from the use of organisational development methodologies is how knowledge is constructed within organisations. Within sociology and social theory (Callinicos, 2007) there are two opposing models of how society is constructed; structure and agency. Structure emphasises a downwards conflation approach to society which claims that social activity is determined by the social structures in which it operates. Alternatively, agency claims an upwards conflation in which social structures are determined by the free actions of those acting within them.

Within critical realism, structure and agency are fluid; changing depending upon the given situation, but neither can be explored in isolation of the other (Archer, et al., 1998). As such, the transitive dimension of reality represents the role of the agent, whilst the intransitive dimension of reality represents the structure in which the agent operates. This notion of structure and agency shares similarities with Giddens' (1979) theory of structuration, although there are also important differences between the two theories.

According to Giddens' theory of structuration, structures exist and perform a role in determining the actions of those operating within them. However these structures are not permanent and are liable to change depending upon the actions of the agents operating within them. Consequently it holds both a downwards and upwards conflation depending

upon the situational context. Part of Giddens' argument is that within this duality of structure, agents are able to change their position in a structure through reflexivity, with knowledge having the potential to be emancipatory. It is this emancipatory aspect of structuration theory that is partly applicable to this study. However unlike structuration theory, where agents alter their place in a structure through reflexivity, Bhaskar suggests that 'activity reproduces or transforms them; so they are themselves structures'. This subtle difference emphasises that agents are not necessarily aware of their role within structures via the process of reflexivity, but can still have an active role in modifying the structures in which they operate.

On an epistemological level this is of importance in relation to collaborative research, where knowledge is argued to be created through social interactions between different groups rather than through isolated individual judgements (Barnes, 1977). This perpetuates the notion that to an extent, structures determine the actions of the individuals operating within them. However because individuals within one structure are not homogenous, complicated interaction is created that impacts upon the development of the structures through social interaction, and even the individual perceptions of such structures that people hold. Patomäki and Wight (2000) support this argument by stating that "every social act, event, or phenomenon is only possible insofar as the conditions for action exist as well as the agents that act; conditions which, we argue, are real and not reducible to the discourses and/or experiences of the agents" (p.230). Consequently agents are unable to be entirely separated from the structures in which they operate.

This perspective is of importance to this study as the research methodologies, AI and AR, rely upon an upwards conflation where the agents operating within the structures of healthcare services are able to modify their own behaviour through reflexivity in order to transform the services that they either receive (for service users) or provide (for healthcare professionals). For service users in particular they may do this whilst being unaware, such as through reporting on their own safety.

3.4.3 Transitive and Intransitive Dimensions of Reality through Mixed Methods

Within health services research the positivist paradigm has been dominant, although there has been a recent shift to appreciate the input that interpretivist research can have on healthcare. Evans et al. (2003) provided an updated version of the traditional hierarchy of research, in which methods are assessed by effectiveness, appropriateness and feasibility, rather than just by outcomes. This places greater emphasis upon interpretive studies by placing them alongside randomised controlled trials in appropriateness and feasibility. In

addition, qualitative research, both individually and in combination with quantitative research, has been identified as a useful process for understanding healthcare systems and processes of delivery (Cunningham, et al., 2011), which further supports the use of mixed methods within this study.

There has also been an increasing amount of support for using mixed methods in healthcare (Barbour, 1999; Devers, 2011; Weiner, et al., 2011), though Bryman (2007) highlights that a universalistic discourse of mixed methods, where researchers select its use based on past experiences and preferences rather than applicability to the research question, should be used with caution as the wrong methods could be selected. Instead, a particularistic discourse should be utilised where the methods are selected based upon the research question. In this study, it is the latter that has been utilised in relation to the chosen methodology, where the methodologies have been selected to specifically address patient perceptions of safety in OCTs, and to develop and pilot a reporting tool.

Barbour (1999) highlights four uses of combining quantitative and qualitative approaches in health research; providing insights into the processes of data construction, helping identify relevant variables, providing explanations for unexpected findings and hypothesis generation. It is the identification of relevant variables that applies to this study, where Barbour (1999) identifies that “where one wants to take a new slant in looking at an established research question, there is also justification for looking at additional variables” (p.41).

A particular feature of this study was the eventual creation of a quantitative reporting tool that is designed to capture the interpretivist perceptions of safety. Although this combination of interpretivist and positivist approaches may appear paradoxical, the qualitative methodologies utilised in this study explored and uncovered patient interpretations of the single reality that is safety within organisational care transfers. These interpretations are not classed as individual or multiple ‘truths’, but are instead equally valid perceptions of a single reality. Quantitative methods have long been established as being appropriate for measuring a single reality, and therefore it is fair to make the assumption that just because interpretations differ between healthcare professionals and patients, the methods used to measure them should not.

3.5 Methodology

This section outlines the methodological approaches that are used in conjunction with the philosophical assumptions of the study; AI and AR. These are fundamentally similar approaches, with the exception that AI explores what works well in organisations and AR attempts to address problems and facilitate improvement. An explanation of how they combine together is provided to clarify how the intricacies work together to provide a robust methodology in this study.

3.5.1 Appreciative Inquiry

AI is a methodological approach to research which ‘concentrates on exploring ideas that people have about what is valuable in what they do and then tries to work out ways in which this can be built on’ (Reed, 2007, p. 2). It is based on the early work of David Cooperrider (Cooperrider & Srivastva, 1987) and comprises a number of principles and assumptions, each of which relate back to the philosophical approaches of this study. AI was utilised within this study primarily in Phase 1 to explore how patients perceive their safety, although many of the principles and assumptions were carried through into Phase 2.

3.5.1.1 Principles and Assumptions

AI is based upon five principles, which have been widely identified in a number of books that explain how AI can be used as a method of organisational development (Cooperrider, Whitney, & Stavros, 2005; Hayes, 2010; Reed, 2007). These principles are detailed below.

The *constructionist principle* relates to the interpretivist philosophical assumptions of AI, which state that individual thoughts and perceptions shape the world, rather than objective observations. The result of this is that there are many different ‘truths’, and the role of AI is to establish the way that these ‘truths’ provide power to individuals and help to shape the world and systems that they operate within. Although this does not sit distinctly within the critical realist paradigm in that it takes an absolute interpretivist approach, the constructionist principle is instead applied by stating that the individual interpretations do not provide ‘truths’, but instead valid perceptions of reality.

The *principle of simultaneity* states that the investigation of organisations and their subsequent development are not independent processes, but instead occur at the same time. Therefore, “an *inquiry* is an intervention in the way it stimulates reflection and thought that lead to different ways of thinking and doing” (Reed, 2007, p. 26, emphasis author's

own). This is of importance as it is arguing that organisations require active participation and subsequently social interactions in order to develop.

The *poetic principle* states that people construct their own world by choosing the stories that they are most interested in. One of the methods of AI is to encourage people to focus on positive experiences, thus shifting their attention and interest away from negative experiences. According to Reed (2007), one of the assumptions of this principle is that there are multiple realities that are created in the moment. The ontological position of this study contradicts this principle in that critical realism, as already stipulated assumes a single reality with multiple interpretations. However the ontological assumptions of critical realism still result in the same outcomes as the constructionist principle; individual interpretations do not provide 'truths', but instead valid perceptions of reality, which can be selected based upon personal interest.

The *anticipatory principle* is that the direction of a person's thought will affect the direction of travel. If the person is able to look positively to the future, then that is where they will end up. Similarly, if the person looks to the future with a negative outlook, then they will feel that trying to change their circumstances is futile. This is also strengthened by the assumption that carrying forward parts of the past gives people more confidence to go through a change process rather than being in a position of starting from nothing.

The *positive principle* states that by focusing on positive experiences, people will be more engaged and for a longer period of time. This in turn results in people becoming more engaged in the organisational development process by capturing their interest and reducing potential barriers that may exist when exploring negative experiences.

3.5.1.2 Affirmative Topic Selection

Within most forms of AI, the topic is usually identified by the research participants as one that they want to develop, such as improving medical education for nursing students (Farrell, Wallis, & Evans, 2007). This is usually based on what they deem to be valuable, and has been termed as the affirmative topic choice. However due to the nature of research funding, in contrast to small-scale organisational development process, it can be difficult to explore areas of value without any prior research. Instead of relying upon the participants to inform this part of the study, the topic was selected based on literature that has identified patient safety being an issue to service users, and that in a publicly-funded healthcare service, safety should be driven by moral obligations rather than financial. This formed the affirmative

topic selection, with the researcher entering into the process post-topic selection, though prior to any methodological decisions.

Organisational care transfers were chosen as the field of the research after an introductory meeting between the researcher, supervision team and with the then Acting Strategic Head of Patient Safety at the NESHA, who identified that it was an area somewhat limited in research and one that was high in risk, which has also been identified within the literature (e.g. Cwinn, et al., 2009; Davenport, et al., 2009; Forster, et al., 2004; Forster, et al., 2003).

3.5.1.3 Processes of Appreciative Inquiry

AI as a method of organisational development is usually displayed as a cyclic process. There are two different types of AI cycle depending on the researcher, the 4-D cycle (Discovery Dream, Design, Deliver) and the 4-I Cycle (Initiate, Inquire, Imagine, Innovate). They both consist of the same principles and assumptions and can be used interchangeably as their processes are identical in everything but name. Throughout this study, the 4-D cycle will be used, which has received the most amount of attention, such as in Cooperrider's AI Handbook (Cooperrider, Whitney, & Stavros, 2005). The 4-D cycle consists of Discovery, Dream, Design and Deliver processes (Figure 3.2).

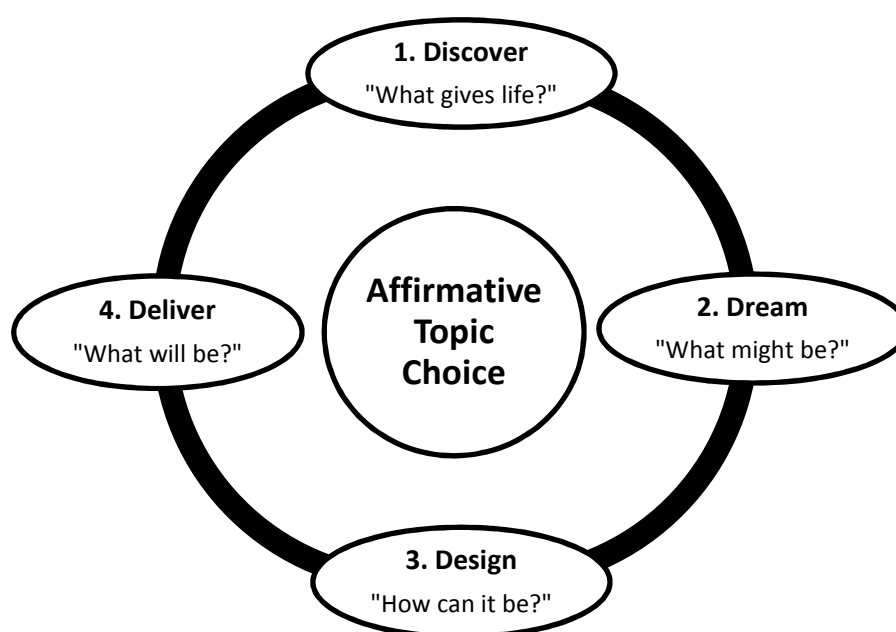


Figure 3.2: Appreciative Inquiry 4D cycle (adapted from Cooperrider, Whitney, & Stavros (2005))

The first stage of the cycle after the affirmative topic choice is **Discover**, where one sets out to find what gives life to an organisation, or what the best experiences have been in a given situation. It is this stage that makes AI a unique form of inquiry, as other similar methodologies such as AR begin with finding out what currently does not work. Cooperrider, Whitney and Stavros (2005) identify that during the Discovery process, “stakeholders share the story of exceptional accomplishments, exploring the “life-giving” factors of the organization. Discovery is an inquiry process to begin identifying themes in the stories told by those interviewed” (p.86).

The second stage of the cycle is to **Dream**, or to envisage what could be in the future. Within organisational development, it is thought that this stage is the most important for inspiring change as people begin to see what can be better within their own setting. The dream stage is practical in that the data remains rooted in the history of the organisation, but becomes generative as participants move away from this history in their explorations of what might be.

The third stage is **Design**, which sets about determining how this improved organisation, as identified in the dream stage, can be constructed. The act of discussing what might be better is not in itself a strong enough catalyst for change, but instead input is required from key stakeholders to co-construct what a better future may be. Cooperrider identifies that the design stage needs to “fully integrate the “best of past and possibility” and that it be consistent with the intended outcome of the inquiry” (p.142).

The fourth stage of the AI cycle is to **Deliver**, which has also been called the Destiny stage. This stage emphasises the need for the Dream to be achieved, and works towards achieving the Dream through the development of existing processes that were identified during the Discover process.

3.5.1.4 The Use of Appreciative Inquiry in this Study

AI has been adapted to be used in the study setting of patient perceptions of safety within organisational care transfers. Therefore instead of attempting to create appreciative learning cultures amongst participants, it instead addressed issues associated with power structures that exist within the NHS, where patients have historically been passive recipients of care. Although this has recently been changing within healthcare, it is still apparent within patient safety. There are some exceptions, such as in hand-washing campaigns (e.g. Pittet, et al., 2011) and other research interventions (e.g. Byrd & Thompson, 2008) aimed to improve patient safety practices of clinicians, however this has not often been present within OCTs. It

was therefore useful to explore with the patients their own perceptions of safety within OCTs. This was a unique challenge that presented itself, as by removing the healthcare professionals from Phase 1, it shifted the emphasis away from organisational development.

By not including healthcare professionals in developing the definition of safety and through the use of AI, the service user perspective was given precedence over healthcare professionals' perspectives. These particularly included where the patient may conceal their true feelings so as not to offend their healthcare provider. It is thought that the exploration of patient perceptions of safety helped to address the imbalance that exists in definitions of safety.

3.5.1.5 Appreciative Interviews

Although AI has been traditionally seen as a method of organisational development, there has been support of its use as a standalone interview method (Michael, 2005; Schultze & Avital, 2011). In doing so, the same assumptions and principles of AI methodology remain, but focuses specifically on “retrospective and prospective reflection, between past and future trajectories, and between personal and collective frames of reference” (Schultze & Avital, 2011). By focusing participants on the Discovery process, they will tend to drift towards the Dream stage naturally (Michael, 2005), which can then be used as a springboard for organisational development.

As contact with patients would only consist of a single interview in Phase 1, there was a need to develop the interviews in a manner which would still capture the fundamental principles and assumptions of AI. By thinking of AI as a research tool rather than a method of organisational development, the Discover and Dream stages were incorporated into the interview schedule to create appreciative questions such as ‘did you feel safe during any of these transfers?’ (Discover) and ‘If you were to go through a care transfer next week, what could be done to make you feel safer?’ (Dream).

The positive principle employed by AI states that by focusing on the positives, participants will be more engaged. This was reflected within this study whereby keeping to a positive framework, the participants were able to talk more openly about their safety than if they had been asked questions about being unsafe. They did not have to fear upsetting anyone, and were reminded prior to the interview that anything they said would remain confidential unless it revealed that somebody was at risk. Furthermore, because experiences of being safe are far more common than experiences of being unsafe, the use of AI meant that there was a

larger population from which to purposively sample. At the same time participants would not necessarily have had hidden agendas, such as to make complaints, although ethical procedures were put in place should any complaints or evidence of unsafe care arise as a result of the interviews.

In keeping with the poetic principle, it was important for participants to select the organisational care transfer that was most memorable for them. Participants were asked to think about recent organisational care transfers that they had been through, how recently they were and who was involved in them. However it was common for participants not to remember the exact details. It was not the aim of the study to audit the OCTs that participants had been through. To insist upon participants recalling these details would have put undue pressure on the research participants to recall information that was not readily available or meaningless to them, and so it was important to provide them with space from which to tell the stories that held the most importance to them. If the feelings of safety that they exhibited were more important than the specific details of the transfer, then this is the interpretation that they hold of reality, which was the subject of the interview.

3.5.2 Action Research

AR is similar to AI in that it is a methodological approach to research that utilises the process of inquiry to facilitate change in organisations on a local level rather than aiming to create findings that are generalisable. Although definitions of AR differ depending upon the investigator and the topic of investigation (Altrichter, et al., 2002), Stringer (2007) has provided a definition that reflects how AR is defined within this study; “a collaborative approach to *inquiry* or *investigation* that provides people with the means to take systematic *action* to resolve specific problems” (p. 8, emphasis original authors' own). White and Verhoef (2005) utilised an AR approach to empower patients in enhancing an integrative approach to their care alongside healthcare providers, policy makers and researchers. The use of AR has been further identified as a clear option to explore service user and carer involvement (Meyer, 2000), although the exact topic of involvement is unspecified.

AR is suggested to be *democratic*, in that it enables everyone of relevance to be involved, *equitable* as it acknowledges the contributions that individuals can make, *liberating*, by removing any barriers and debilitating conditions which may inhibit development, and *enhancing*, by enabling individuals to express their full potential. These are all structured within an interpretivist epistemological basis, where knowledge is constructed through

experiential learning (Huang, 2010). Again the interpretivist paradigm fits with the transitive dimension of critical realism.

This study utilised Participatory AR, which emphasised the collaborative nature of the research. In particular, the participants throughout the study acted as co-researchers in different forms depending upon their profession (e.g. healthcare professional or service user). This enablement of participants to be co-researchers has been identified as an essential component of participatory AR (Stringer, 2007). The exact role that each profession holds within the study changed throughout and will be discussed later.

AR takes the form of a cyclic process of organisational development similar to AI. There are numerous different names for the different stages within the AR cycle, although they are mostly based on the same principles. This study utilised the Plan, Act, Observe and Reflect cycles (Kemmis, 2009), which resonate closely with the Institute for Innovation and Improvement's Plan, Do, Study and Act cycles of change management, which have proven popular throughout the NHS (Langley, et al., 2009).

Within this study, the Plan stage of AR related to the physical development of the reporting tool, whether in the form of workshops or through participant evaluation. The Act stage reflected the piloting of the reporting tool by the healthcare professionals, whilst Observe and Reflect stages encompassed the ongoing evaluation of the reporting tool by both the healthcare professionals and the service users. These were all underpinned by the patient perceptions of safety that were identified in Phase 1.

3.5.2.1 Collaborative Working

Collaborative working amongst patients, healthcare professionals and organisations has been receiving increasing attention, in relation to both the patient and public involvement agenda and organisational care transfers. The use of AR within this study helps to fulfil this agenda by encouraging organisations and professionals to work together across these organisational and professional boundaries. Huzzard et al. (2010) in particular highlighted that within an AR study, the researcher is able to act as an 'active constructor' rather than a 'neutral discursive gatekeeper' in developing a collaborative initiative. This active construction was propagated through providing the discourse of patient perceptions of safety to healthcare professionals.

Furthermore, collaboration has been identified as an essential process for knowledge translation (Bellman, Webster, & Jeanes, 2011). By using an AR methodology that incorporates collaboration into its fundamental workings, this study naturally bridges the knowledge translation gap by involving healthcare professionals working at the micro level with the research outcomes, meaning that they are enabled to use current, ongoing research findings in their current practice.

3.5.2.2 Power Structures

Power has been defined as “not simply a relationship between partners, individual or collective; it is a way in which certain actions modify others... [it] exists only when it is put into action” (Foucault, 1982, p. 788). This suggests that power is not a solid entity that remains in one state, but is instead in a position of constant flux, coming into and going out of existence depending upon individual actors and organisations that influence other’s actions, either directly or indirectly, and either immediately or in the future. Therefore any reflections on power relationships need to take into account the individual contexts of both time and place, with an acknowledgement that these are liable to change. Although Foucault has received criticism for not acknowledging the shift away from individualism towards patient-centeredness in healthcare (Bleakley & Bligh, 2009), his thoughts on power are still of relevance, particularly within participatory AR and the field of organisational development in general.

Power is a central tenet of participatory AR as it aims to give people more power by reducing inequalities. This links into the fundamental argument of this study, whereby patients are argued to have less power in their perspectives and consequently reporting of safety incidents. Miller (1992) writes about power in an educational collaborative research project from an autobiographical perspective. Many of the power issues that exist between educators and students also exist between healthcare professionals and patients, especially in the context of collaborative research that challenges perspectives. Miller calls for spaces to be created, within which people are given the opportunity to have their voice heard. By giving people these spaces within this research via the reporting of their safety, patients were given a voice they may not have had previously. This in turn can be seen as an emancipatory act.

Patient and public involvement resonates strongly with Foucault’s perspective on power, suggesting it should be explored through the study of resistance (Foucault, 1982). Foucault identifies that power struggles are not always anti-authoritarian, but rather occur as a result

of the effects of such power. In particular he identified that the medical profession is often not criticised because it exercises uncontrolled power over people's health. However the recent trends and awareness of patient safety issues has resulted in a changing shift in this power, and as such there is now a greater emphasis on patient involvement and being open. Furthermore, the use of participatory research methods has been suggested to challenge systems of power and control that are established through traditional healthcare research methods (Baum, MacDougall, & Smith, 2006).

3.5.3 The Use of an Appreciative Framework to Address Power Issues

Through the use of AI, organisations were reassured that patients would not be asked to identify any unsafe practices or feelings of being unsafe, therefore not reproducing any complaints mechanisms, but instead be asked what had and would make them feel safer. This meant that the organisations were unlikely to perceive the research as being a threat to their current routines in contrast to if unsafe care had been explored. The recruitment of organisations that already focused on quality improvement work also assisted in providing ease of access.

By asking the healthcare professionals to recruit participants on my behalf, they were able to select people whom they thought would be the most appropriate to discuss feeling safe. Recruiting participants in this manner meant that healthcare professionals were unlikely to be able to introduce any bias through the selection of potential participants who had had good experiences. Instead the selection of potential participants that would show the healthcare professionals in a positive manner will have supported the methodological approach to the research of exploring positive experiences of safety. Despite this, healthcare professionals identified a number of participants who had had negative experiences of their care. This suggests that they were either unaware that these negative experiences had occurred as they were outside of their care at the time, that patients had been unable to express any concerns of safety (thus supporting the need for a reporting tool) or that they were aware and because of having a positive patient safety culture felt that it was appropriate for their balanced views to be heard.

3.5.4 Combining Appreciative Inquiry and Action Research

There are many similarities between AI and AR that are borne out of their philosophical assumptions and their goals of organisational development. They both share the same assumption that organisational development occurs best through a cyclic process of engagement and collaboration, where the participants also act as co-researchers. Within this

study, these cycles have been partially mapped onto each other to demonstrate the different approaches that were taken in each phase (Figure 3.3). This diagram is presented throughout the thesis at the start of each stage of the cycle. The Discover and Dream processes of AI were utilised heavily in the exploration of how patients perceive safety within organisational care transfers during Phase 1. These perceptions were then taken forward as a basis for the full AR cycle in Phase 2.

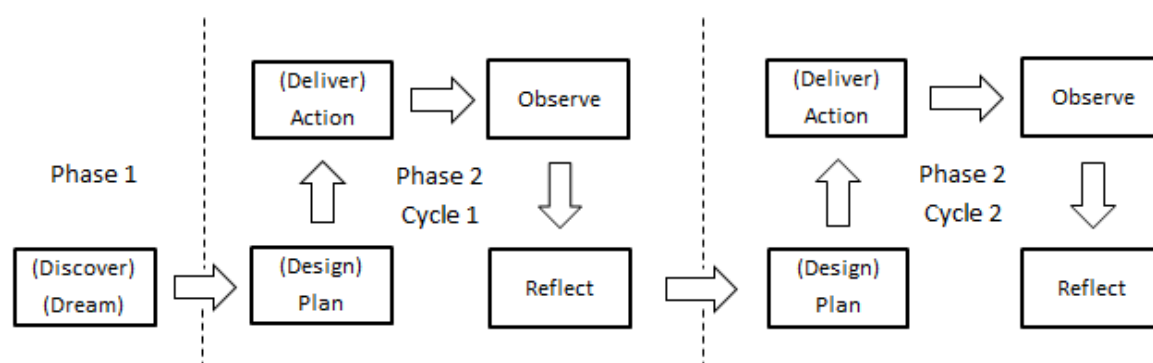


Figure 3.3: How the two different methodologies link together. The Appreciative Inquiry processes are in brackets.

In addition to the cyclical nature of AI and AR, they both share the same epistemological foundations of interpretivism, that knowledge is constructed through action, and this action can provide voices to those that have previously been harder to hear. The ontological assumptions can also both be placed within the critical realism framework that this study has adopted, where interpretations of reality play an important role in how this reality is measured. To the extent that they share similar characteristics, AI was developed as an alternative form of AR (Cooperrider & Srivastva, 1987; Reed, 2007) which strengthens the argument that they can be combined into a mutually reinforcing process for the purpose of this research.

However there are also some differences between the two methodologies that need to be addressed. The first of these is that AI focuses on the positives, building on what works well, whilst AR is traditionally based upon what does not work or what is poorly understood, and tries to resolve or fix it. This issue is addressed by splitting the study into two phases, where the positives taken from patient perceptions of safety can be used to underpin the problem that is trying to be resolved in the second phase. Additionally, AI does not simply ignore any negative experiences or perceptions that arise, but places them within a positive framework through the assumption that what people see as a negative, the opposite would be a positive. Within this study, it was deemed that in addition to the negative experiences being

interpreted within an appreciative framework, the positive experiences could also be interpreted within a negative framework.

3.5.5 Identification and Recruitment of Key Stakeholders

Parand et al. (2010) found that medical engagement in improvement programmes is a complex socio-political and motivational issue where different individuals have different approaches and perspectives. This can be even more relevant in patient safety research and the domain of patient involvement, which are arguably more socio-political than general improvement programmes as a result of the blame cultures that often exist within healthcare organisations.

Due to the complex nature of the research there were a number of key stakeholders that play numerous roles within the research. From a methodological standpoint they are identified as stakeholders because they each have a particular interest in the study; patients will benefit from being involved to a greater extent in their safety and healthcare organisations and professionals have an opportunity to learn to a greater extent from patients. Their individual roles as participants will be developed further in relation to the phases of the study.

Once OCTs had been identified as the focus of the research, it was identified that it was necessary to involve organisations that cross not just NHS boundaries but also organisational ones. The rationale for this was that the most complicated care transfers, where there is an increased chance of an error occurring (Cook, Render, & Woods, 2000), occur across organisational boundaries that involve different types of healthcare provider. After discussions with the Care Transfers clinical theme lead, it was decided that nursing homes would be appropriate organisations to include in the study as they have a high frequency of transfers. In addition, there were already quality improvement projects being undertaken within the region to improve safety within these transfers, albeit with a focus on improving communication practices such as discharge summaries. Consequently the Improvement Foundation (IF) which was running these initiatives assisted in the identification of key stakeholders.

The IF acted in the capacity of a bridge-builder, contacting both social and private care homes to enquire as to their interest in taking part in the research, and organising a first meeting to discuss the research in more detail. This proved to be an invaluable resource in the early stages of the research as it meant their contacts and knowledge could be utilised.

In particular they were able to identify which care homes within the region were open to ongoing quality improvement and had a good patient safety culture; an organisational requirement that was established in the planning of the study.

From these meetings, two private nursing homes and two social care homes agreed to take part in recruiting participants in Phase 1. Although the service users would most likely be transferring into NHS units, it was acknowledged that patients coming from an NHS setting would strengthen the recruitment of participants. After meetings with a research and development manager within an NHS Trust, it was decided that community care teams within the NHS would be an appropriate place from which to recruit participants.

There were two reasons for this, the first being that community care teams have a large volume of patients transferring into and out of their services, and the second being that it was thought they would be able to target younger people. The second of these was a high priority as the social and private nursing homes had already been invited to take part, and their patient base is elderly people. The implications and limitations of this purposive sampling are discussed within the methods chapter.

3.5.6 Assessing the Quality of Data

Mays and Pope (2000) identify that there are a number of ways to assess data quality, including the triangulation of findings and respondent validation, which are the two main methods of quality assessment that will be utilised in this study.

Triangulation, although usually conducted with other sources of data that have been collected by the researcher to compare with the same participants, was conducted in relation to existing literature to provide support for the findings. This same data also influenced the data analysis process, as it is argued that deductive modes of knowledge creation are inevitable as it is not possible to remove oneself from that which one has experienced. Other methods of triangulation, such as participant observations and healthcare professional perspectives were ruled out as it is believed that these would not convey the service user interpretations of their safety, but would overly influence the findings from an already medically dominated perspective.

Triangulation also occurred through the comparison of patient reports of safety from Phase 2 and the themes that were generated in Phase 1. When reporting safety, patients had the

option to identify other factors that had made them feel safe or unsafe, therefore for patients not to identify any other practices suggests that they are supportive of Phase 1 findings.

Likewise, **verification** of the findings by healthcare professionals to see if they accurately determined how safe or unsafe a patient was during the transfer they discussed was ruled out because again, it is important to capture how patients perceive their safety. Instead, it was felt that respondent (participant) verification would be the most appropriate means of verifying the data. This ensures that any interpretations of the interviews by the researcher are accurate and convey their interpretations.

In Phase 1, participants were returned to after themes had been identified by the researcher from the interview transcripts, meaning they had a chance to add new data or to refute any misinterpretations. The use of dyadic interviews has also been suggested to provide verification for participant statements and to generate a richer understanding of needs and experiences than with a single participant (Kendall, et al., 2009).

3.5.7 The Embedded Researcher

One major difference between qualitative and quantitative research is that the researcher can be embedded within the research during the former, whereas with the latter the researcher is supposed to be removed from it by being objective. One of the key concepts of organisational development is that the researcher can be in one of two positions; an outsider to the organisation, where their knowledge and experiences do not always relate to the particular setting that they are looking to develop, or an insider, where they have an intricate knowledge of the structures and practices that exist within organisations. Although these appear discrete, they are in fact fluid and it is possible for a researcher to move from one to another.

(Huzzard, Ahlberg, & Ekman, 2010) state that the action researcher is not a passive boundary object within an interorganisational collaboration, but instead acts as an active constructor. This means that the researcher is embedded within the research to a greater extent than if they were acting as an outsider. Consequently there is a greater requirement to be reflexive of the role that the researcher adopts during the intervention, with a particular emphasis on the political nature of any such intervention.

Reed (2007) highlights that being an outsider is the most common position for a researcher, and reflects the position of the researcher at the outset of this study. There are two major

themes that span both the advantages and disadvantages; experience and power. These two themes are not independent of one-another, but instead form a complicated reciprocal relationship.

There were a number of advantages that presented themselves from being an outsider going into the organisations. The first of these was a lack of experience in a clinical or safety-orientated setting. This provided a greater degree of independence; there were no local interests from being embedded within the organisation such as promotion or internal-politics, and there was no pre-existing bias or prejudice against organisations, providing a greater degree of objectivity, although this is not to be confused with a realist interpretation of objectivity. On top of this, a lack of experience meant that any institutionalised healthcare cultures, whether positive or negative, did not impact upon this objectivity; views and questions could be proposed and asked that an insider may not.

A lack of experience also provided a number of advantages with respect to the power relationships that developed over the course of the study. Working across different types of organisations such as private nursing homes, social care homes, NHS community care teams and NEAS, independence meant that there was no professional prejudice, which may have been equally perceived by the organisations and participants within the study. Independence also played a major role in the recruitment of organisations to the study, as they would not have perceived it to be as much of a threat as an individual that was embedded within the patient safety movement or within one individual organisation, thus potentially increasing their willingness to cooperate.

The disadvantages can be more easily split into separate experience and power issues. A lack of experience working in a professional setting, in particular one related organisational care transfers, has meant that at times the processes involved in organisational care transfers have been confusing. This is only perpetuated by the complex nature of transferring patients between boundaries (Cook, Render, & Woods, 2000). There was also a lack of intimate knowledge that healthcare professionals have around the common patient safety issues that occur within organisational care transfers in their own particular setting. This lack of experience extends beyond that of processes, but also includes networks and organisations. For this reason, trust was placed in others to guide the targeting of organisations and healthcare professionals.

The disadvantage associated with power relates to how healthcare professionals perceived the study and the researcher. Outsiders are often seen with suspicion (Reed, 2007), and

working in negative patient safety cultures would have only exacerbated this where people will have wanted to cover up or deny, either intentionally or unintentionally, that patient safety is a concern for their organisation. For this reason organisations were selected based upon either previous experience with quality improvement work (private nursing homes and social care homes), or based upon high levels of safety incidents reported (primary care trusts), which was deemed to reflect a positive patient safety culture. This was supported by the use of AI.

In two instances, a nursing care home was approached that had not previously been involved in quality improvement work, and no contact had been made beforehand by a gate-keeper. Although they were both open to discussions regarding the research, they later dropped out prior to recruiting anybody as they stated they did not have the time, or with the second nursing home failed to return any telephone calls or emails after the first meeting. This is perhaps a reflection on the difficulties of including organisations that have no history of quality improvement work or whose priorities may lie elsewhere, and may also demonstrate self-selection bias of the organisations that did participate in the study.

3.6 Chapter Summary

Table 3.1 presents an overview of the methodological strategy of this study. The final three sections of the table; methods, data and analyses, were not explored within this chapter but are instead detailed within Chapter 4.

Research process	Methodological strategy
<i>Philosophical paradigm</i>	Critical realism and Structuration Theory
<i>Research approach</i>	Qualitatively-driven mixed methods
<i>Research design</i>	Appreciative Inquiry and Action Research
<i>Methods</i>	Interviews, Workshops, Questionnaires
<i>Data</i>	Qualitative (Interviews, Workshops) and Quantitative (Questionnaires)
<i>Analyses</i>	Thematic analysis (Interviews, Workshops) and descriptive statistics (Questionnaires)

Table 3.1: Summary of the methodological strategy.

In this chapter the epistemological and ontological assumptions of the study were outlined. Critical realism was introduced as the philosophical framework, in which there is an ontological single reality, or the intransitive dimension of reality, with multiple interpretations. These interpretations, existing within the transitive dimension of reality, differ depending upon the person observing the reality, thus providing an argument that service users perceive reality differently to healthcare professionals and are thus able to identify unique components of safe care that are otherwise unknowable by healthcare professionals.

The use of mixed methods allows for the exploration of these two different dimensions of reality. Qualitative methods provide an insight into the transitive dimension of reality, and quantitative methods are then able to identify specific patterns within the intransitive dimension. Both methods allow for the exploration of underlying causal mechanisms.

In addition to the philosophical assumptions, this chapter also introduced the methodological approaches to the study, whereby an entanglement of AI and AR provide the overarching methodologies. In particular, AI is used as an interview technique to explore how service users perceive safety, whilst the two cycles of AR provide the direction of developing, piloting and redesigning the reporting mechanism. Finally any power issues that are associated with the use of AR are discussed, along with how the researcher's position as an 'outsider' to the organisations can impact upon the study. The following chapter will detail the specific methods utilised within these methodologies.

Chapter 4: Methods and Outline of Findings

4.1 Chapter Overview

The purpose of this chapter is to present the methods that were used in the various phases and stages of the research cycles. They are broken down into three distinct categories of methods; patient perceptions of safety, development of the reporting mechanism and the piloting of the reporting mechanism. The patient perceptions of safety section addresses the methods used in Phase 1 of the study to develop the patient definition of safety that eventually informed the development of the reporting mechanism.

Phase 2 was split into two different methods sections that are representative of how the findings are reported. The first of these was the development of the reporting mechanism, which constituted the methodological stage of Plan (Design) of the first research cycle. This had its own methods section because it was unique to the rest of the research cycles, as once the reporting mechanism was developed, it was then modified based upon feedback during the cyclic AR stages. The second methods section relating to Phase 2 encompasses the piloting of the reporting mechanism, and any subsequent modifications that were made to the reporting mechanism.

After the methods for these sections are reported the final reporting mechanism is presented alongside an outline of the findings chapters. This is to guide the reader when reading the subsequent three findings chapters, which will trace the development of the reporting mechanism from defining safety to piloting.

4.2 Methods

Although the study was split into two phases - defining safety from the patients' perspectives and development of the reporting mechanism - for the purpose of reporting the methods and the findings it is more appropriate to report the latter in two separate forms; the development and the piloting of the reporting mechanism. The development only constituted one stage of the AR cycle (Plan (Design)), but it constituted quite distinct methods to the rest of the research cycle.

In the reporting of data, abbreviations are used so as to anonymise participants. Within these abbreviations, # represents one digit. P## is used for participants interviewed in Phase 1 of the study, Pil## for participants interviewed in Phase 2 as part of the evaluation and ### for respondents to the reporting mechanism. Healthcare professional abbreviations are

provided in Table 4.2. In addition to these abbreviations, the use of '[...]' indicates that data has been removed in order to provide clarity to the quote. It was ensured that the meaning of the quotes remained the same.

4.2.1 Phase 1: Patient Perceptions of Safety

4.2.1.1 Recruitment

The following section on recruitment outlines the process that was undertaken to identify and recruit key stakeholders and individual participants. The key stakeholders represent the organisations that were recruited to participate in the study, whereas the individual participants are those with whom I wanted to explore perceptions of safety. As a result of the overarching AR methodology, the key stakeholders (organisations) played an important role throughout this phase of the research. As such it was important to purposively recruit the organisations that in turn would recruit the individual participants. This section therefore comprises not just the recruitment of individual participants in Phase 1 of the study, but also the recruitment framework of the entire study as this impacted on individual recruitment.

Sampling Framework

Within qualitative research, sampling frameworks are often used in the purposive sampling of participants so as to ensure a wide variety of individuals are included. Within this study, a sampling framework was devised so as to provide a guide for which organisations and participants would be targeted. The sampling framework was developed to purposively sample a small number of individuals from a range of different organisations within the North East of England and encompasses both the organisational traits and the individual traits of potential participants.

There have been arguments over the difference between different methods of sampling within qualitative research, with some authors differentiating between purposive and theoretical sampling (Barbour, 2008; Coyne, 1997). This study takes the perspective supported by Barbour (2008) and Coyne (1997) that all sampling in qualitative research can be classed as different types of purposive sampling, where the sample is selected intentionally based upon the needs of the study. Barbour (2008) defines purposive sampling as “selecting interviewees [...] by virtue of characteristics thought by the researcher to be likely to have some bearing on their perceptions or experiences” (p. 52), and it is this form that is used throughout this study.

Organisational Recruitment

The sampling framework for the organisations that were to be recruited to the study outlined a number of requirements. The first of these were that the organisations had to display an affinity towards patient safety that represented having a patient safety culture rather than a culture of blame. The reason for this was that it was felt any organisation with a blame culture may not be open to the scrutiny that research requires when looking at patient safety in an attempt to cover up errors for fear of retribution (Department of Health, 2000b; Reason, 1998). This fear would only have been increased as the study was funded by the North East SHA PSAT. Although there are some measures of patient safety cultures (e.g. Colla, et al., 2005), it would not have been appropriate to carry out patient safety culture surveys on each potential organisation due to time constraints. Furthermore, at the point of recruiting organisations, the North East SHA did not actively measure patient safety cultures, meaning there was no pre-existing data on which to base the decision. It was for this reason that organisations only had to demonstrate an affinity towards patient safety.

This was assessed in one of two ways depending on the organisation type. For NHS organisations, the numbers of patient safety reports by healthcare professionals over a 12 month period were compared with other organisations in the region. For social and private nursing homes, this information was not available. Instead, culture was assessed through their current contributions to quality improvement initiatives that had been operating within the region.

NHS Community Care Teams

NHS community care teams were selected at the point of the NHS Research and Development (R&D) application by the R&D manager in order to purposively recruit individual participants. Three teams were recruited from two NHS trusts where it was believed it would be possible to recruit younger service users. Managers of the respective teams were requested to purposively target younger people, however after recruitment had begun, conversations with each of the managers led to the conclusion that the number of transfers involving younger people into their care was too infrequent, and the timescales of the study meant that recruitment needed to occur relatively quickly.

The use of community care teams also provided a unique perspective in that there has been a steady move towards more care in the community rather than admitting people to hospital, which has been suggested to improve care (Low, Yap, & Brodaty, 2011). Patients have been reported to be aware of this trend, and were supportive of it as they deemed it safer and

more practical than being transferred into hospital (Kielmann, et al., 2011). The involvement of community care teams was of greater significance as they are deemed important to the safety of patients by patients.

Social Care Homes and Private Nursing Homes

Social care homes and private nursing homes were recruited via the Improvement Foundation, an organisation that was working closely with the North East SHA to deliver quality improvement initiatives. These tended to focus on reducing healthcare acquired infections in social care homes and private nursing homes, but they were also running a quality improvement project which aimed to improve the transfer of information when patients were admitted to or discharged from these services. As a result of their quality improvement work, they had a detailed database of social care homes and private nursing homes within the North East of England that were willing to be involved in various improvement initiatives. From this list, seven homes from across the region (Durham, Middlesbrough, Newcastle and Sunderland) were identified and initial contact meetings with the researcher were organised by the Improvement Foundation.

After the initial meetings, three care homes decided not to participate, citing time and resources as the main reason, with one stating that the majority of their residents had dementia, and thus would be ineligible for the study. Consequently, two social care homes and two private nursing homes agreed to be involved in both phases of the study. The next section on individual participant recruitment details the demographics and characteristics of the individual participants recruited into this study.

Individual Participant Recruitment

The sampling framework for individual participants stipulated that they had to be aged 18 or over, able to give informed consent, and to have undertaken an organisational care transfer within the last 6 months, or alternatively had extensive experience of organisational care transfers in the last five years. Extensive experience was classified as having gone through more than two organisational care transfers in the last five years at the point of recruitment. Table 4.1 gives a full overview of the inclusion and exclusion criteria applied to individual participants.

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Aged >17 • Able to give informed consent • Undertaken an organisational care transfer in the last 6 months, or; • Extensive experience of organisational care transfers (>2 in the last five years) 	<ul style="list-style-type: none"> • Aged <18 • Unable to give informed consent • No experience of organisational care transfers

Table 4.1: Inclusion and exclusion criterion for participants in Phase 1.

A sampling grid was devised to ensure that equal numbers of participants were sampled where possible based on age, gender and experience of care transfers. However given the larger recruitment strategy for both individuals and organisations, this proved difficult to complete. In particular, the organisations that were involved in the recruitment resulted in a population that consisted of largely older people that had more females than males. As such the emphasis of the study shifted towards older service users going through an organisational care transfer, and the weighting of females to males is slightly more representative of the general trend in the ageing population.

Fourteen participants were recruited aged between 56 and 88 (mean age of 76.2), of which ten were female and four were male. It was originally envisaged that twenty participants would be recruited, although this was reduced to fourteen as it was felt that data saturation had occurred with regular themes emerging from subsequent interviews. During the recruitment of all participants, they were invited to include a family member, carer or advocate. The rationale for this was that patients are often accompanied by someone when they are being transferred, and that person may be able to provide a different viewpoint on safety than the participant, or to give prompts. Three participants, P03, P04 and P08, had a carer or family member present to form a dyadic interview.

The participants were recruited from three community care teams spanning two NHS trusts (n=7), two City Council Resource Centres (n=3) and two private nursing and residential care homes (n=3). A further participant, who was not under the care of any of these organisations, was also recruited opportunistically. She was a family member of a current participant (P03), and she discussed her own experiences of going through care transfers as a patient. She was fully informed about the purpose of the study and was given an information pack and a consent form to sign. The respective managers and/or team leaders from the organisations were given the inclusion and exclusion criteria (see Table 4.1) and

were asked to select potential participants. This responsibility was to ensure that people included in the study were able to provide informed consent as the researcher did not have the relevant qualifications to assess this.

4.2.1.2 Interviews

Semi-structured interviews, based on the AI methodology, were developed in order to explore what had made patients feel safe during organisational care transfers in the past and what would make them feel safe in the future. These were based on the Discover and Dream processes of AI, and the use of semi-structured interviews gave participants the necessary freedom to discuss topics that are of the most importance to them as required by the poetic principle (Reed, 2007).

An interview schedule was created to provide prompts for both the researcher and the participant as it has been identified that important information may be missed “not because it is not relevant[...] but simply because it has momentarily slipped his/her mind” (Barbour, 2008, p. 119). This included contextual questions aimed at exploring the participant’s experiences of organisational care transfers, questions aimed at finding out what had made them feel safe, and questions aimed at finding out what would make them feel safe in the future. For a full version of the final interview schedule please see Appendix 13.

In the interviews where a family member, carer or advocate was present, they were given an information pack and they signed a consent form as they were actively contributing to the interview. Despite having a reply slip in the information sheets for the participants to complete if they wanted to be contacted, the majority of the participants gave verbal permission for their respective care team to organise the interviews with the researcher on their behalf.

The participants were given a choice as to where they would like the interview to take place. Eleven participants chose to hold the interview in the same location that their care was being provided, whereas two interviews with participants from city council resource centres chose to have the interviews at home due to convenience as they had recently been discharged. For those interviews conducted where members of their care team were nearby, there was no apparent effect on the interview or the answers given to questions. The use of appreciative questions helped to mitigate any effect that the interview location may have had, as participants would not have been hesitant discussing positive aspects of their care.

In one instance, the participant (P02) requested that the interview wasn't voice recorded, stating that she didn't like voice recorders. Instead, detailed notes were made, and once the interview was complete the researcher verified that what had been written was an accurate account of the interview. The notes were then typed up post-interview. A further participant (P03) requested for the interview to be stopped part of the way through (see page 109). This may have also been the result of the slightly repetitive nature of the questions. As a result of this, I made it clear to future participants at the start of the interview that some questions may appear to be repetitive, and a pre-emptive apology was given.

As the interviews were conducted, the question order was modified in order to tackle a small number of issues which are detailed below. It was decided before data collection began that piloting the interview schedule would be an ongoing process. Pope, Ziebland and Mays (2000) identified that data analysis begins during data collection, with collected data informing future questions that may be asked. Although this was not a formal process within the study, it is an inevitable part of qualitative data collection as the researcher is working in the field (Pope, Ziebland, & Mays, 2000). The first modification consisted of changing the question order after the first interview as it was thought that the original order provided a discussion with the participant which was incoherent. An example of this ambiguity within the original interview schedule is that the participant was asked 'how do you feel about the process of being transferred?' before being asked 'can you tell me about a time when you've felt safe going through a care transfer?' This had the potential to cause confusion as the participant was being asked about their feelings of the process prior to being asked what the process actually entailed.

The second set of modifications was made after the fifth interview to accommodate having a family member present during the following interview and to try and capture their perspectives. Changes were also made to the question order as participants were asked about their experiences of going through a safe transfer before discussing what the term safety meant to them.

The third set of changes was made after the eighth interview. This consisted of adding a particular question regarding if the participant had any experiences of feeling unsafe. Although this appears to oppose the principles of AI, it is necessary to pay attention to negatives in order to dream about how the world could be better. Changes were again made to the question order to create a more logical order, and the question 'are you aware of any means for you to tell someone about how the process has been for you?' was moved to the

end of the Dream section as the greatest emphasis from the question is 'Is this something that you think should exist?', rather than if it already does exist.

4.2.1.3 Data Analysis

The interview recordings were transcribed immediately after data collection, although due to some interviews occurring shortly after one-another, this was not always possible. Instead, analysis was completed as soon as possible afterwards. NVivo 8 was used as a tool to systematically code and analyse the data, which has been suggested to improve the rigour of the data analysis process (Welsh, 2002).

Although the interview was split into the Discover and Dream processes of AI, thematic analysis was utilised to highlight key themes that spanned the two processes. The purpose of this was to provide a full account of the concepts, explanations and terms used by service users when discussing safety regardless of whether they were discussing what currently works well or envisaging what would work well in the future.

Thematic analysis was chosen as the method of data analysis as it has been identified as being "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). In doing so it is a flexible method of data analysis that spans different epistemological frameworks (Braun & Clarke, 2006). The result of this is that data is not analysed in an epistemological vacuum, but rather the researcher's own epistemological assumptions are embedded within the data analysis process (Braun & Clarke, 2006). Fereday and Muir-Cochrane (2006) identify that thematic analysis can be a joint process of inductive and deductive analysis. Within this study the deductive influences of the researcher are evident in addition to the inductive development of the themes, which are discussed in section 4.6.3.

During the interviews, participants sometimes spoke of negative instances of, or unsafe care. Although coding these appears to go against the principles of AI of focusing on the positives, Cooperrider, Whitney and Stavros (2005) have stated that "Everything people find wrong with an organization represents an absence of something they hold in their minds as an ideal image... One could argue that there is no such thing as negative data, for every utterance is conditioned by affirmative images" (p.95-96). As such the 'negative data' that was collected was interpreted using an appreciative lens, working on the assumption that what participants deemed to be unsafe care, the opposite was safe.

Initial codes were developed inductively by moving participants' statements into multiple codes that summarised what it was they were saying when talking about safety. Once these were all compiled, they were then grouped together into overarching themes. It is recognised that researchers do not operate in an epistemological vacuum (Braun & Clarke, 2006), and so it would be naïve to claim that the final themes were developed through a pure inductive process. They still hold many components that resonate with healthcare definitions of safety that exist within the literature, although these have been developed in consideration of how the patient has perceived them. During the process of compiling the final themes, a degree of deductive processing occurred, which has also been termed theory-driven coding and is recognised to be the most common process of coding qualitative data (Boyatzis, 1998; Braun & Clarke, 2006).

Although theory-driven codes have been highlighted to be vulnerable to projection from the researcher based upon their cultural bias (Boyatzis, 1998), it can be argued that this has been constrained within the development of the codes in my study. For example I have previously argued that on an epistemological basis, healthcare professionals inherently have a different perspective of safety than service users based upon their working cultures, experience of safety and principal experience of healthcare as a practitioner rather than a service user. As I do not hold these perspectives, I am not constrained by them and will have been able to identify more closely the different perceptions that service users hold.

It is for this reason that the process of data analysis is an interpretive act of the researcher, and one which requires reflection in order to identify potential influences, and verification of the emergent themes so as to ensure accuracy as to their original meaning. Data verification is addressed in the following section, whilst reflection is addressed in section 4.6.3.

4.2.1.4 Data Verification

Participant verification, sometimes referred to as respondent validation (Mays & Pope, 2000), is a process of assessing the quality of data in qualitative research. It is based on the premise that when a researcher analyses qualitative data, they may introduce their own deductive reasoning into what should be an inductive process, which may ultimately influence the emerging themes (Mays & Pope, 2000). Therefore participant verification serves to reduce this from happening by asking the participants to confirm or refute the data by establishing a level of correspondence between the researcher's interpretation and the participant's perspective (Mays & Pope, 2000). This can be done at different stages of data collection, for example by asking participants to verify transcripts pre-analysis or to review

themes post-analysis. However Barbour (2001) warns that asking too much of participants may place excessive demands on their time and may also be distressing. It was for this reason that participants were only approached with a summary of the themes.

The researcher contacted each of the participants to discuss the themes that had arisen as a result of the data analysis. Out of the fourteen participants, six were revisited after data analysis had been completed. Each of the six verified that the themes that had been captured were accurate, and felt that they did not have anything else to add. From the other eight participants, two preferred that the findings were posted out to them and six were not contactable via telephone. The findings were posted to their last known address with a letter explaining that if anything was incorrect or missing then they should contact the researcher. No contact has been made since the letters were sent.

4.2.2 Phase 2: Development of the Reporting Mechanism

4.2.2.1 Process of Developing the Reporting Mechanism

Workshops were the primary method of developing the reporting mechanism. They brought together a wide variety of stakeholders, including service users, expert patients and various healthcare professionals from the different organisations involved in Phase 1. This afforded the opportunity for the different stakeholders to present their unique experiences and perspectives. It was decided that the two workshops, each lasting three hours would provide enough time to develop a first draft of the reporting mechanism, which would then be further developed and adapted based upon feedback from patients and healthcare professionals involved in the distribution.

Bringing these different stakeholders together provided a unique collaboration between various healthcare professionals spread across various sectors and service users. Interdisciplinary collaborations have been defined as “an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own” (Bronstein, 2003, p. 299) and have been identified as being important to tackle complex issues (Ovretveit, et al., 2002). There are many different variations of collaborations, depending upon the number and types of organisations involved, processes that exist in these organisations and the resources that are available to both the organisation and the quality improvement project. With regards to the latter, there were a limited number of resources available for conducting this study, meaning that financial support for participants was unavailable other than travel expenses for service users.

The role of collaborations spanning organisational and professional boundaries within AR have been labelled as social constructions, where the researcher is an active rather than a passive mediator across these boundaries (Huzzard, Ahlberg, & Ekman, 2010). The role of the researcher within this study was very much as an active mediator, bringing different professions and organisations together to achieve the goal of developing the reporting mechanism.

The following section details the methods that were implemented in the two workshops. Where appropriate, these are combined across the two workshops, with any differences highlighted along with the rationale behind those differences.

4.2.2.2 Recruitment

In keeping with the overall sampling framework of the study, participants were sampled purposively for the two workshops. An overview of the participants of both workshops who contributed to the development of the reporting mechanism is provided in Table 4.2. Service users that participated in Phase 1 of the study were invited to attend both workshops so as to create continuity between the two phases of the study. It was thought that they would be able to provide their own unique perspective that had previously contributed to the definition of safety reported in Chapter 5. Despite the invitation, no service users volunteered to participate. Instead, the links between the two phases of the study were artificially established via a presentation introducing the participants to them. This was done in the two workshops as there were new participants who had not been exposed to the findings previously in both.

In addition to service users from Phase 1, expert patients were also invited to participate. They were identified as being expert patients due to their active involvement in the PCPE network, which had also acted as a steering group for the study. In total, four expert patients were invited to participate in the workshops, with three in attendance. The fourth dropped out after confusion over the time of the workshop. It was originally decided that having an equal number of service users (either from Phase 1 or expert patients) to healthcare professionals would provide a balanced perspective from the two groups. However as no service users from Phase 1 volunteered, there was insufficient time to recruit others before Workshop 1. This was addressed in Workshop 2 through the inclusion of service users from the Northumbria University Service User Network, which consists of service users who are involved in the education of healthcare professionals at Northumbria University.

Healthcare professionals from organisations involved in the recruitment of participants in Phase 1 were also invited to participate in the workshops. This consisted of three NHS community care team nurses, two social care home managers and two private nursing home managers. The invitation including piloting of the reporting mechanism, meaning that it would be tailored to their systems, providing an established link between the reporting mechanism and how the data could be used to improve their services.

In addition to these healthcare professionals, the Ambulance Service Trust was invited to send two participants. Although they were not to be involved in the piloting of the reporting mechanism, it was hoped that they would provide a unique perspective into the journey stage of the organisational care transfer that other healthcare professionals may not possess. In Workshop 1, two paramedics attended, whilst in Workshop 2 two safeguarding adults leads attended. The healthcare professionals were chosen by the Ambulance Service as being the most appropriate people.

The two private nursing homes were unable to send a representative to attend Workshop 1. One dropped out of the study, citing a lack of available time and resources to develop or pilot the reporting mechanism. The other representative, the manager of the care home, attended Workshop 2. A representative from the SHA (YK) who was involved in organising the Patient, Carer and Public Engagement network also attended both workshops, providing a supporting role via the facilitation of groups and also having an active input into the discussions.

Participant Role	Organisation	Workshops Attended	Workshop 1 Group Number	Workshop 2 Group Number	Abbreviation
Expert Patient	PCPE Network	1 and 2	1	1	EP
Expert Patient	PCPE Network	1 and 2	2	1	EP
Expert Patient	PCPE Network	1 and 2	2	2	EP
Service User	Northumbria University Service User Network	2	-	2	NUSU
Service User	Northumbria University Service User Network	2	-	2	NUSU
Service User	Northumbria University Service User Network	2	-	2	NUSU
Healthcare Professional	Ambulance Service	1	1	-	ASP
Healthcare Professional	Ambulance Service	1	2	-	ASP
Healthcare Professional	Ambulance Service	2	-	2	ASSA
Healthcare Professional	Ambulance Service	2	-	2	ASSA
Healthcare Professional	Social Care Home	1 and 2	1	1	SCHM
Healthcare Professional	Social Care Home	1 and 2	2	1	SCHM
Healthcare Professional	NHS Community Care Team	1	1	-	CCTN
Healthcare Professional	NHS Community Care Team	1 and 2	2	1	CCTN
Healthcare Professional	Private Nursing Home	2	-	1	PNHM
Strategic Health Authority Representative	Strategic Health Authority	1 and 2	1	1	SHAR

Table 4.2: Group constitutions and abbreviations of roles of participants involved in the development of the reporting mechanism.

4.2.2.3 Structure of the Workshops

Workshop 1

Participants were split into two groups depending on their professional role and organisation that they were recruited from. Group 1 consisted of an expert patient, a paramedic from NEAS, a social care home manager and a nurse from an NHS community care team. Group 2 consisted of two expert patients, a paramedic, a social care home manager and a nurse from an NHS community care team. These are summarised in Table 4.2. This required a degree of flexibility from participants to work in groups without a hierarchy of professions, identified as a key component of collaborative working (Bronstein, 2003).

The workshop began by providing participants with an agenda for the session (Appendix 14) and providing feedback to participants on the results of Phase 1 of the study. This was done through a presentation at the beginning of the workshop highlighting the different themes that patients had defined as being important to safety, whilst including quotes to provide clarity and evidence as to where the definitions had come from. At the same time all participants were provided with a hand-out containing a summary of the findings, helping to ensure that the mechanism was based upon these findings.

Participants were able to relate to and discuss the findings from Phase 1 throughout the session in relation to the development of the reporting tool. Upon recollection of a poor experience of healthcare by an expert patient, a healthcare professional stated:

- “It’s just recognition isn’t it? What you’re describing here is as well, I think it’s the apology, it’s not being listened to and it’s not knowing who to speak to. They’ve gone against everything that Jason’s found is good practice” [SCHM, Group 1]
- ‘[CCTN] - Patients might think that something is unsafe when it’s not but they can be reassured to reduce / stop this worry’ [JS observation notes, Group 1]

Observation notes by PD also refer to a discussion held around the findings from Phase 1. These portray a different perspective of the findings from Phase 1, where only one small segment relates to apology, and none relate to blame. It is possible that this reflects the participant’s perspective of a patient reporting mechanism for patient safety where it is seen as a mechanism to attribute blame to healthcare professionals.

- ‘[CCTN] Should the questions relate to the themes in Phase 1? Human error, apology, blame’ [PD observation notes, Group 2, emphasis is PD’s own]

Two questions were developed to focus the development of the reporting mechanism, which were introduced in the form of two break-off sessions. The first of these questions was ‘What will the mechanism look like?’ which provided participants with the opportunity to develop ideas for what a reporting mechanism would resemble. Two sub-questions were provided to guide participants in their thinking; ‘What format will the mechanism take?’ and ‘What questions will the mechanism ask?’. The second of the questions was ‘How will it fit with current systems?’ which was designed to tackle the issue of how the reporting mechanism could be implemented into their respective organisations. The questions in Workshop 1 are shown in Table 4.3, along with cues given to participants.

Break-off Session	Main Question	Sub-Questions	Cues
1	What will the mechanism look like?	What format will the mechanism take?	Healthcare professionals; how do you want service users to report back to you?
			Service users; how do you want to report back to healthcare professionals?
		What questions will the mechanism ask?	Healthcare professionals; what do you want service users to tell you?
			Service users; what do you want to tell healthcare professionals?
2	How will the mechanism fit with current systems?		

Table 4.3: Workshop 1 questions and cues given to participants.

Following each of the break-off sessions, groups provided feedback to the other group on what had been discussed and written on the flow-chart paper. This allowed both groups to come together and discuss each other's interpretations of the answers. In the instance of the first question, this provided an opportunity for the groups to come to a shared understanding of what the mechanism would look like, before considering how it would fit with existing mechanisms and procedures.

Workshop 2

In order to ensure continuity from the previous stages of the research (Phase 1 and Workshop 1), many of the participants who had previously contributed to the study were invited to attend Workshop 2 (see Table 4.4). This meant that seven participants were able to bring forward their knowledge from Workshop 1, in particular the key principles that were identified as being important in the reporting mechanism. Five of the participants had had no exposure to the study previously, and were introduced via the introductory presentation. All participants were provided with an agenda for the session (Appendix 15).

Slides	Rationale for Slides
Purpose of Today	Provide participants with a clear objective for Workshop 2
Background and Phase 1 Findings	Create a link between Phase 1 and Phase 2 so that participants knew what the reporting mechanism needed to be based upon
Aims of Reporting Mechanism	Provide clarity to participants what the reporting mechanism is and is not trying to capture
Workshop 1 Findings	Principles of the reporting mechanism provided for participants not in attendance at Workshop 1
Thinking Differently Methods	Participants were introduced to the Thinking Differently methods so that they understood what was expected of them
Ground Rules	It has been identified that the use of ground rules are essential when using Thinking Differently methods (Maher, et al., 2007)

Table 4.4: Overview of introduction presentation to participants at Workshop 2.

As part of the introductory presentation, participants were introduced to Thinking Differently methods (Maher, et al., 2007), which are a set of tools aimed to increase the creativity of participants. Although Thinking Differently is often referred to as a methodology, within this study it was used as a toolkit within the overarching AR methodology. The fundamental basis of these tools is that individuals hold schemas, or mental structures of the world, and thoughts are channelled through those. The schemas are separated from one another, meaning that it can be difficult to think outside of these mental structures, or to think differently. This in turn inhibits the ability for potentially novel ways of doing something to be introduced into or alongside existing systems. For example, participants in Workshop 1 were unable to move away from the thought process that if patients are to report something, it must be their satisfaction; indicative that they had been unable to move outside of their patient reporting schema.

To encourage participants to think outside of their traditional schemas, Workshop 2 was split into two break-off sessions; divergent and convergent thinking (see Figure 4.1). To facilitate this, participants were given four thinking differently tools; ‘fresh eyes’, ‘reframing by word play’, ‘pause, notice, observe’ and ‘random word, picture or object’, which were implemented into the divergent thinking session.

‘Fresh eyes’ asked participants to think how the problem looked from a different perspective. On a basic level this could have been from a patient’s or healthcare professional’s

perspective (depending upon the participant's own role), or they could have envisaged the issue from a unique perspective, i.e. that of a fast food restaurant or tabloid. A list of different perspectives was provided to participants (for the full list see Maher, et al., 2007). 'Pause, notice, observe' performs a similar function, encouraging participants to discuss what other organisations, outside of healthcare, have done to resolve a similar problem.

'Reframing by word play' is based upon mental benchmarking, where participants were asked to describe a current, similar process and to reduce it down to its most simple terms. This helps to reduce jargon that may be attached to current schemas, and participants are then able to recognise schemas that are similar in constitution. 'Random word, picture or object' encouraged participants to think of something that is usually unrelated to the existing schema and to produce ideas based upon it. In order to aid this, participants were provided with a list of random words (see Maher, et al., 2007), and were asked to choose one at random to discuss.

These four tools were selected as they were deemed to be the most appropriate of the Thinking Differently tools to use within a workshop with tight time constraints. In addition to the tools, participants were also provided with 'ground rules' on what was acceptable and what was not. These included that participants were not allowed to criticise an idea, a large quantity of ideas was more important than quality, participants should encourage wild ideas, they should build on the ideas of others, there should only be one conversation at a time and laughter was a good sign that they were thinking differently.

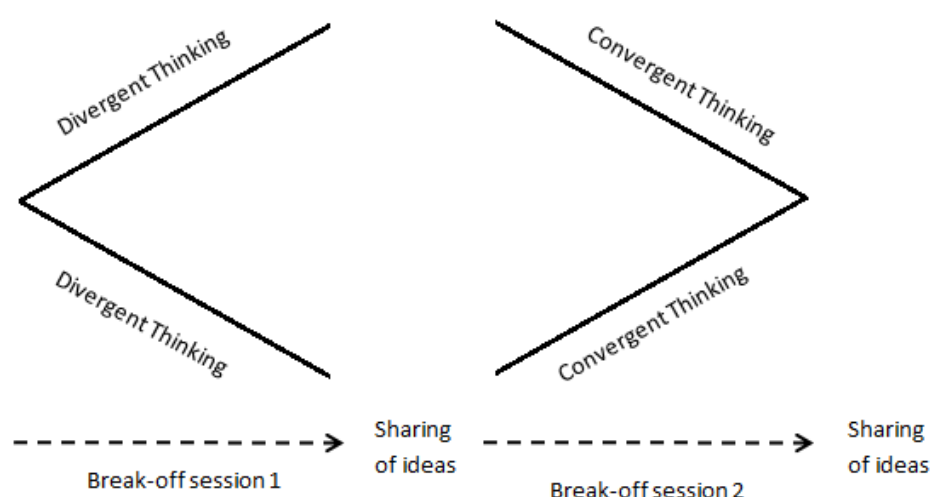


Figure 4.1: Structure of Workshop 2 in terms of divergent and convergent thinking.

Group constitution took a nuanced approach, with participants able to sit where they felt most comfortable. There were no issues raised with the group constitution of Workshop 1, and as participants were not expected to share their experiences, it was not necessary for them to be split between their professional roles; instead they were being asked to create something new, rather than to examine processes already in existence in their respective organisations.

Following each of the break-off sessions, participants were asked to feedback what they had discussed to the rest of the group. After break-off session 1 this gave the opportunity for groups to digest ideas from the other group, as opposed to creating an open discussion. A wider discussion involving both groups was held following break-off session 2. The facilitator for Group 1 (JS) and Group 2 (AJ) provided a summary of the discussion points to the wider workshop by using the flipchart paper.

4.2.2.4 Data Collection

The same methods of data collection were incorporated into the two workshops, and so are reported together below. Five data collection methods were implemented in the workshops to capture the discussions and ideas that participants held on the development of the reporting mechanism; voice-recordings, flipchart paper, observations, post-it notes and blank paper.

Flipchart and blank paper were provided so that participants could write down their thoughts and design ideas for the reporting mechanism. By using flipchart paper, participants were encouraged to share and discuss their ideas with the group, meaning that the final design was a sum of the individual ideas of participants. The flipchart paper was used at the end of each break-off session for participants to share their ideas with the other group. Post-it notes were also provided to participants so that they could write down any ideas that they either felt uncomfortable discussing in the group, or felt that they had gone unheard by other participants.

Voice recordings were of the individual groups during the break-off sessions, which took the form of activity-based focus groups. In the same manner as Workshop 1, these voice recordings were aimed to capture the conversations that participants were having in their own group and to understand the decision-making processes that contributed to the design of the reporting mechanisms, as well as capturing the ideas that participants presented

during the divergent thinking session. Due to a technical issue, the voice recorder in Group 2 did not capture the convergent thinking break-off session.

Observations of each group were also carried out where possible so as to triangulate the data collected and to be able to reflect upon the process of developing the reporting mechanism. These were conducted by the researcher (Group 1) and the researcher's supervisor (AJ; Group 2). The observation notes were limited in their detail as both observers were facilitators of a group each. AJ has had previous experience of facilitating groups and has worked previously with the service users in Group 2. It was for this reason that she was asked to facilitate Group 2 as the service users were likely to be more forthcoming with a familiar person.

4.2.2.5 Data Analysis

Workshop 1

As the data was emergent it was not possible to plan the data analysis a priori. Instead it was analysed based upon the different themes and concepts that had arisen during the workshop. This centred on the flipchart paper markings that summarised the discussions that the groups held, along with the sticky dots that were applied to them. From this, the observations and the voice recording were used to analyse the discussions that underpinned the flipchart paper, also exploring the underlying group dynamics that may have impacted upon the outcome of the workshop, such as professional boundaries between the various healthcare professionals and service users.

Workshop 2

Data analysis was conducted concurrently through the process of convergent thinking. In particular this consisted of drawing upon the ideas that the two groups formulated during the divergent thinking session, and working as individual groups to assess the shared ideas and bring them into a tangible reporting mechanism that could then be piloted. This was further expanded following the convergent thinking session where the two groups again came together to share the reporting mechanisms, and a brief discussion was held over which parts of each were the strongest. This is an unorthodox but applicable method of data analysis that is embedded within the AR methodology, whereby the participants are involved as co-researchers in the data collection and analysis (Baum, MacDougall, & Smith, 2006). Additional data that was collected, such as voice recordings and flipchart paper, was used post-workshop to ensure that the reporting mechanism had accurately captured what the

participants had discussed during the workshop. Any discussions not directed around the development of the reporting mechanism are not reported.

4.2.3 Phase 2: Piloting of the Reporting Mechanism

4.2.3.1 Organisations

A feature of AR is that participants are also engaged as co-researchers (Baum, MacDougall, & Smith, 2006). Within this study, the healthcare professionals who were engaged in the development of the reporting mechanism were also invited to pilot it within their own organisations (n=6), moving back to being co-researchers as they were in Phase 1, instead of participants as they were in the workshops. The reporting mechanism was piloted in NHS community care teams (n=3), social care homes (n=2) and a private nursing home (n=1). One nurse from each of the community care teams was given the responsibility for distributing the reporting mechanism, which was not necessarily the same person who had attended the workshops. The same social care home and private nursing home managers who attended the workshops were responsible for piloting the reporting mechanism in their organisations.

By having this continuity over the different phases of stages of the study, it has meant that the findings from Phase 1 have not had to have been transferred to settings from which they were not developed. This has helped to ensure that they are still relevant for the populations for which the reporting mechanism had been developed.

4.2.3.2 Sampling Strategy

For each round of piloting, 20 reporting mechanisms were given to each of the individual teams or organisations involved in both Phase 1 and the development of the reporting mechanism. A total of 120 were distributed to organisations in each cycle of piloting, with piloting lasting up to 14 weeks depending on the speed at which they were able to be given to service users. The first cycle of piloting began on 1st November 2010 and ended 21st January 2011 (12 weeks), and the second cycle began on 21st February and ended 27th May 2011 (14 weeks). The second cycle of piloting was extended in order to give organisations more time to distribute the reporting mechanisms.

In addition to the piloting of the reporting mechanism, service users were invited to participate in an interview as part of the ongoing evaluation. They were sampled opportunistically based upon those who had completed the reporting mechanism and had

stipulated that they would be willing to be interviewed. Two service users volunteered to be interviewed in Cycle 1 of the piloting, with one being accompanied by their carer. There were no volunteers in Cycle 2 of piloting.

4.2.3.3 Participants

The health care professionals distributing the reporting mechanism were asked to distribute it to any service users entering or exiting their service, regardless of their destination or point of origin. The health care professionals were given the freedom to sample any service users they wished. The only instructions that they were given were that the person they were giving the reporting mechanism to had to be able to give informed consent. The private nursing home specifically targeted service users based upon their willingness to complete the reporting mechanism, whereas the other organisations distributed the reporting mechanism regardless of willingness. A detailed description of the participants is provided in 6.3.1 and 6.4.1 in relation to Cycle 1 and Cycle 2 of the piloting, respectively.

4.2.3.4 Data Collection

The reporting mechanism was piloted in order to determine the feasibility of introducing a mechanism that allows service users to report their own safety when going through an organisational care transfer. This includes how willing service users are to complete the reporting mechanism, and the types of reports that they provide. In order to achieve this, four types of data were collected in relation to the piloting of the reporting mechanism; the service user reports, an evaluation form for the reporting mechanism, a semi-structured interview with a service user and carer exploring their experiences of completing the reporting mechanism and information on who the reporting mechanism was distributed to, compiled by the health care professionals.

The reporting mechanism and evaluation form were distributed together in a pre-paid, addressed envelope that was being returned to the researcher at the university. The use of pre-paid envelopes has been found to increase the number of responses to questionnaires (McColl, et al., 2001), and was included so that service users did not incur any expenses in completing the reporting mechanism. All documents contained a unique participant number so that they could be collated and compared in relation to the organisation they were distributed from and individual details of each service user. Mechanisms 61 to 80 were lost and subsequently replaced with mechanisms 122 to 141.

The service user reports focused specifically on how safe, rated 'safe', 'neither' or 'unsafe' service users had felt during their organisational care transfer. This was split into three sections; 'your departure', 'your journey' and 'your arrival'. Service users were asked to provide this rating in relation to 'communication from staff', 'staff listening to you', 'departure running to schedule', 'falling or potential falls', 'medication problems or concerns' and 'hygiene'. These were included based upon the findings from Phase 1 of the study (Chapter 5). In addition, service users were asked to provide information on where they had departed from, their mode of transport and where they arrived to.

There have been no studies exploring patient reporting of safety when going through organisational care transfers. This means that there is currently no baseline on expected response rates and willingness to complete a reporting mechanism. However it is possible to extrapolate findings from other patient feedback mechanisms in other settings. The first indicator of a successful reporting mechanism is how willing or able service users are to complete it (Fitzpatrick, et al., 2006; Fitzpatrick, et al., 1998). Another term for this is saliency, which is defined as how relevant, important or interested the participant is in completing a questionnaire (McColl, et al., 2001). For questionnaires, the average response rate is 55.6% (Baruch, 1999), although it has been reported to be as high as 67% for postal questionnaires (Sitzia & Wood, 1998), which the authors recognise is unusually high in comparison to elsewhere in the literature. McColl et al. (2001) identified that non-respondents to surveys are more likely to be elderly people, which has the potential to impact upon the response rates of this mechanism.

Service users were encouraged to complete the evaluation form even if they did not want to complete the reporting mechanism, for example to give a reason for why they did not complete it. During Cycle 1 of piloting, service users were asked to provide feedback on seven items (items 1-7, Table 4.5) on a three-point scale of 'agree', 'neither agree or disagree' or 'disagree'. During Cycle 2 of piloting, a further three items were added to the evaluation form (items 8-10) and item 6 was removed. The additional items were added based on informal feedback from healthcare professionals piloting the reporting mechanism.

Item Number	Item
1	I understood the purpose of the Patient Safety Survey
2	I understood what was meant by 'your journey'
3	I understood each of the questions
4	The questions were appropriate
5	There was nothing missing from the Patient Safety Survey
6	I had no concerns about completing the Patient Safety Survey
7	I feel the Patient Safety Survey allows me to provide useful feedback about the healthcare I have received
8	I experienced difficulties completing the patient safety survey
9	I felt that the colour scheme was useful
10	The size of the text was appropriate

Table 4.5: Individual items contained in the evaluation forms.

In addition to the questions, participants were also encouraged to write comments and to expand upon their answers to ensure that nothing was missed. There was also an option for the service users to participate in an interview so that they could provide more detailed feedback. An explanation of the inclusion of each item is provided in the Reflection stages of the AR cycles (Chapter 7).

The healthcare professionals distributing the reporting mechanism were asked to compile information on who they were distributing the reporting mechanism to. This included their age, gender, ethnicity, if they were a service user, carer or advocate, if they were arriving into or departing out of the service, their medical conditions, if they were receptive to the mechanism and if any questions were asked. During Cycle 2 of piloting, they were also asked if there were any issues during the transfer that the service user was unaware of, such as missing documentation, medications or poor communication. Despite having the form to complete, healthcare professionals often did not complete it when distributing the reporting mechanism. This occurred either due to not having the time, or because the responsibility for distributing the mechanism was shared amongst the healthcare team and they forgot to compile the information. This means that there is often data missing, and any findings and their subsequent implications need to take this missing data into consideration.

4.2.3.5 Data Analysis

The data was analysed in relation to the different stages of the AR cycle; Design (Discover), Delivery (Action), Observation and Reflection. As the first Design (Discover) stage of the research cycle constituted the development of the reporting mechanism (Chapter 6), the first

cycle of piloting began with the Delivery (Action) stage, where the reporting mechanism was distributed to service users.

The Delivery (Action) stages encompass the data from the distribution of the reporting mechanism. This covers the number of reporting mechanisms that were distributed by the different organisations and care teams and the number of respondents. A descriptive account of the service users at the point of distribution and response is also provided, showing the average ages, male to female ratios and points of distribution (either on arrival or departure). A comparison is made between the characteristics of respondents to the target population that it was distributed to. Given the small nature of the sample size, it was not possible to run inferential statistics between the target population and respondents. This data is utilised to contribute towards the measure of saliency amongst service users for the reporting mechanism.

Data regarding the Observation stage is captured in terms of the patient reports of safety; observing what it is that respondents are reporting about their safety and the types of organisational care transfers that they are reporting. Again this is used to determine saliency amongst service users, but also to compare with the number of healthcare professional reports of safety within organisational care transfers, which have identified an incidence rate of around 20% (Tsilimingras & Bates, 2008).

Finally the Reflection stage of the AR cycle was used to explore evaluation data. This was to determine any changes that needed to be incorporated into the reporting mechanism to improve it and to address any issues that service users may have had completing it. Any limitations of the data collection and analysis of these findings are presented in the Discussion (Chapter 8).

4.2.4 Ethical Considerations

When conducting qualitative research with service users it is important to consider the ethical implications of the research, especially in relation to research governance (Barbour, 2008). Outlined below are the ethical considerations that were identified during the planning of the study and the procedures implemented to protect the participants.

4.2.4.1 Informed Consent

The researcher ensured that fully informed consent was obtained from everyone taking part in the study, whether they were the service user or acting in the capacity of a carer, family

member or advocate, healthcare professional or a representative of the SHA. This involved providing the participants with an invitation letter, information sheet and consent form prior to participation, and giving them time to consider them and ask any questions. In the cases where participants were unable to read the consent form for themselves, the researcher read it out to them, and they were asked if they would like more time to consider whether they wanted to take part.

Richards and Schwartz (2002) identified that within qualitative health research, gaining informed consent is often a process rather than a one-off event. Although data collection in Phase 1 often only consisted of a one-off interview, participants were reminded immediately after the interview of their participant rights, and were encouraged to contact the researcher at any time if they had any questions or concerns. For the six participants involved in the participant verification, they were reminded of their rights as participants and were asked if they had any questions or concerns prior to and after the validation. A similar process was initiated for Phase 2, where participants were reminded of the voluntary nature of the study and that there was no obligation to attend either or both workshops. Similarly healthcare professionals were made aware that even when they were involved in the workshops, there was no obligation to participate in the piloting of the reporting mechanism.

There were two situations, both relating to the two private nursing homes in Phase 1 where the healthcare professional had identified a potential participant who had verbally agreed to participate in the study. In the first instance when the potential participant was approached by the researcher to gain informed consent, it quickly became apparent that the individual was not able to understand the purpose of the study or even the consent process itself. Rather than continuing with the consent process, I explained that I would leave the forms with him to complete at a later date should he wish to.

In the second instance, the individual appeared to have capacity to give informed consent. However during the interview it quickly became apparent that she could not follow the questions, and instead of talking about healthcare, her focus was on stories and experiences from when she was growing up. I decided that it would not have been appropriate to stop the interview as she may have been offended, and instead did not include any of her data in the study. The healthcare professional that recruited her was informed of this upon leaving the interview location.

In such scenarios, especially within nursing homes where the residents are likely to have cognitive or speech impairments, it was necessary to be reflexive as to the purposes of them

volunteering to participate (Wilson, 2011). In the former case, it was perhaps that the individual was unaware of what he was agreeing to when approached by the healthcare professional, and assumed that because he was being asked, he had to participate. In the latter case, it was apparent that although she was able to give informed consent, her own agenda was that of wanting company and someone to talk to, an issue that has been recognised when working within care homes where residents may be in need of company or someone new to talk to (Wilson, 2011).

During the piloting of the reporting mechanism, an opt-in procedure for gaining consent was utilised. Service users were provided information on the purpose of the reporting mechanism, but rather than asking them to sign a consent form, they were told by the healthcare professionals that completing the reporting mechanism was voluntary. Therefore any respondents were opting-in to the study. An opt-out system, based upon presumed consent, was rejected as it was deemed unethical (Den Hartogh, 2011).

4.2.4.2 Data Protection, Confidentiality and Anonymity

It is of ethical importance for all participants to remain anonymous, which has been identified as being particularly difficult within qualitative research which often contains many clues as to a participant's identity (Richards & Schwartz, 2002). All data collected on participants was handled confidentially, and any identifying information about them or other people or organisations that they mentioned was anonymised. This was done by using participant numbers instead of names. An overview of how these are presented within the data is on page 95. Any names and locations mentioned during the interviews were removed from data at the point of transcription. The qualitative data collected was not analysed comparatively across the different organisations because the small number of participants recruited from each would have made them identifiable to the organisations they were recruited from.

All personal information collected about participants was stored in a secure, password-protected database to which only the researcher had access. In line with university policy this information will be destroyed immediately upon completion of the research. All non-personal information, such as voice recordings and transcripts were also stored securely and will be destroyed 6 years after completion, again in line with university policy. This included the patient reports of safety and evaluations, of which the physical copies were stored in a locked cabinet inside the university.

4.2.4.3 Breaking Confidentiality

Although confidentiality is of great importance to research participants, there are some circumstances in which this has to be intentionally broken. This is often dictated by legal and regulatory frameworks, where the participant is deemed to be at risk of harm (Wiles, et al., 2008). Despite the assurances given to interviewees regarding confidentiality, they were also informed that if they told the researcher something that put themselves or somebody else at risk of harm, then confidentiality would have to be broken. It was made clear to them that should this happen, they would be informed of what would happen and the person that was informed would be in a position to help. The reporting mechanism was specifically designed to be anonymous, so only when the participant requested feedback would confidentiality have been able to be broken. During the course of the study there were no instances that the researcher needed to break confidentiality.

4.2.4.4 Distressing Stories

A further consideration that needed to be made was the potential for distressing stories to be told. Researchers are required to assess the potential impact that a qualitative interview may have upon the participants (Orb, Eisenhauer, & Wynaden, 2000), and to consider the benefits and harm that it may have upon the participant. It was determined that this study had the potential to impact upon both the participant (in the form of recalling a distressing or painful experience) and researcher (listening to a story that reflected personal experiences or resonates with experiences of family members or friends). A plan was put into place that meant interviewees were aware that they could stop the interview either for a break or completely, and that they wouldn't be left alone until they requested otherwise. They were also given contact details of the researcher's supervisors who were experienced clinicians that would be able to counsel them via the telephone, an option also available to the researcher.

4.2.4.5 Right to Withdraw

Participants involved in interviews or workshops were informed of their right to withdraw from the study at any time without giving any reason. One participant (P03) exercised his right to withdraw, asking for the interview to be stopped half-way through, stating:

- “I think there's a lot of time wasted on these interviews... you come round and ask me certain questions. I don't know. I can't grasp it” [P03]

It was later explained as I was leaving and out of earshot by his wife, who was present during the entire interview that he sometimes gets angry when he loses concentration.

Although the participant requested to withdraw from the study, he was still happy for the data collected up until that point to be used.

4.2.4.6 Researcher Safety

As the researcher was going into people's homes alone a lone worker policy was implemented where the researcher was required to 'check-in' with someone; a supervisor, family member or friend. This required the researcher informing them of the interview location, the interview start time and anticipated interview end time. Any deviation from these would result in the trusted person contacting the researcher to ensure that they are safe.

4.2.4.7 Ethical Approval

The study received full ethical approval by the school Research Ethics Committee and by an NHS Research Ethics Committee (REC). In addition to ethical approval the study also received R&D approval from the relevant Trusts, and in the case of the social care homes, from the city council R&D department. The NHS REC was notified of all minor amendments to the study, including the addition of new sites. There were no major amendments to the study.

4.3 Outline of the Findings Chapters

The following three findings chapters (Chapter 5: Patient Perceptions of Safety, Chapter 6: Development of the Patient Reporting Mechanism and Chapter 6: Piloting of the Reporting Mechanism) are presented in a manner which tells the story of how the reporting mechanism was developed. Chapter 5 outlines how safety was defined by service users who had gone through an organisational care transfer, followed by a discussion of how the findings were of relevance to the reporting mechanism. This encompassed the AI methodology, where the Discover and Dream stages were used to inform the development of the reporting mechanism.

Chapter 6 details how the reporting mechanism was developed through the process of the two workshops detailed previously. These two workshops constituted the start of the AR cycles at the point of planning the reporting mechanism (Design stage of AI). The final findings chapter, Chapter 7, provides a detailed account of the rest of the two stages of the AR cycles, which took the form of two rounds of piloting the reporting mechanism. A full summary of the findings chapters, the methods used to collect the data and the methodology that informed the data collection is provided in Figure 4.2.

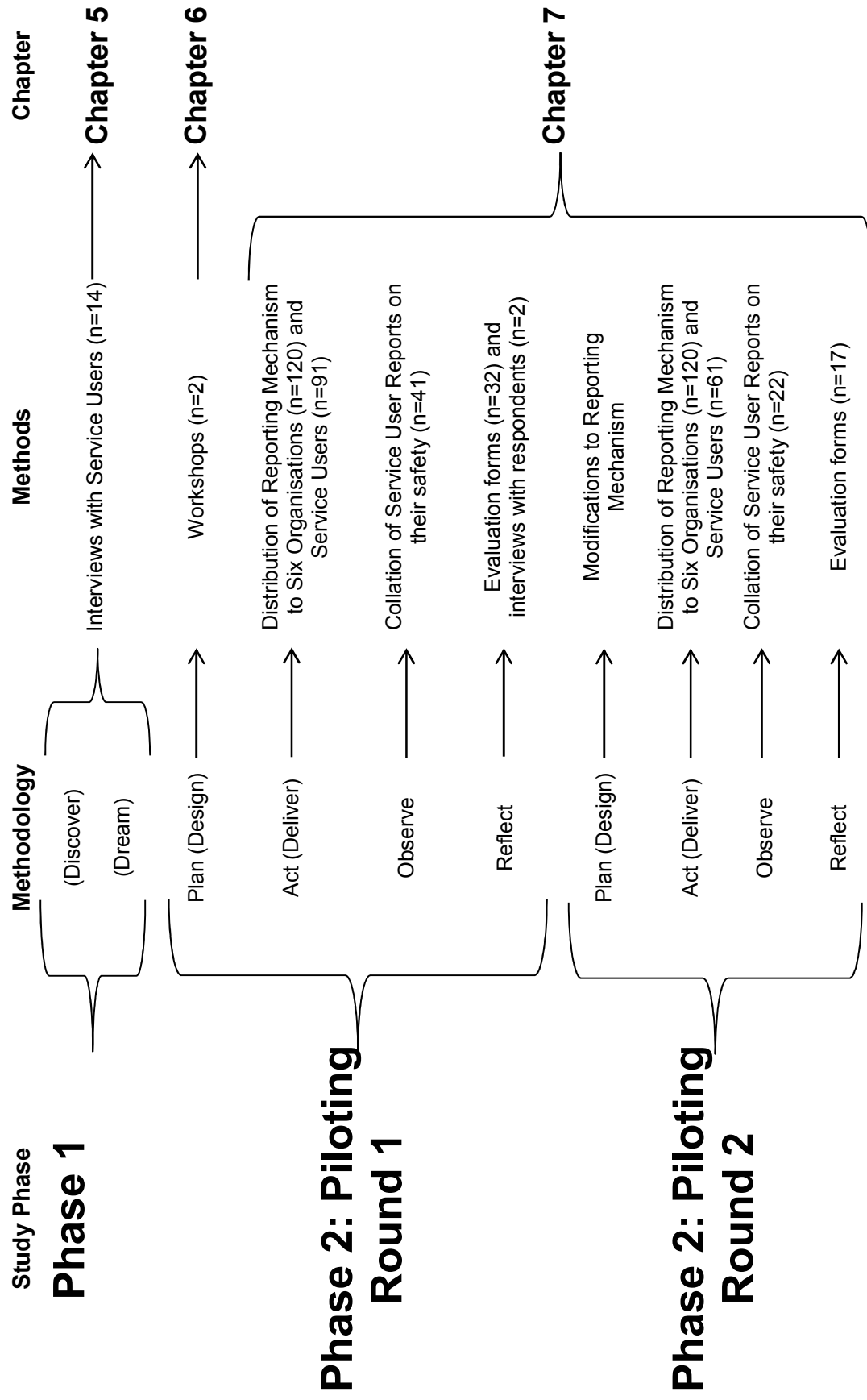


Figure 4.2: A map of how the different phases link with the methodology and the methods, and where the findings are presented in the thesis.

Chapter 5: Patient Perceptions of Safety

5.1 Chapter Overview

This chapter will provide an overview of Phase 1, where patient perceptions of safety were explored using an AI research methodology. Contained within this chapter are the findings and a discussion of how the findings informed the latter stages of the research. In addition a reflective account of the data collection process is included, which provides an overview of the issues that were encountered throughout this phase of the study and how they were addressed. This chapter does not give a full discussion of the findings, but instead aims to provide clarity of the research process leading into the second phase of the study, which requires a small discussion of the findings. The full discussion is located in chapter 8 where the findings of the entire study are explained as a whole.

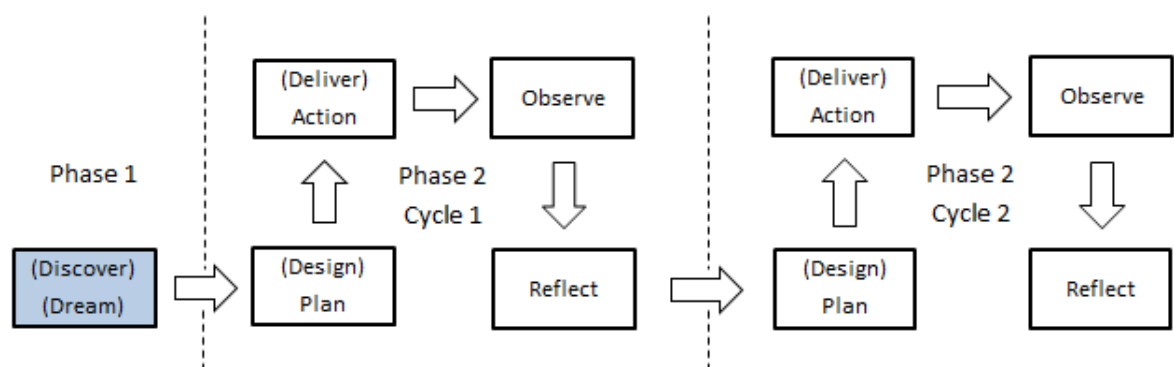


Figure 5.1: Where the service user perceptions of safety fit into the methodological cycles.

5.2 Findings

A number of key themes were identified in relation to what safety means to service users and what made them feel safe when undergoing organisational care transfers. The particular themes that were developed are communication, responsiveness and traditional safety issues. Below is a general overview of these concepts, with a particular focus on the terms and explanations that were used when participants discussed safety. In addition to these themes, trust was also regularly discussed by the service users. Trust was separated from the other three themes as they all refer to actions or events impacting upon safety, whereas trust appeared to impact upon perceptions of safety.

5.2.1 Communication

There are many components to effective communication between healthcare professionals and service users that lead to feeling safe, such as being informed, having a means with which to contact healthcare professionals and apologising when something goes wrong. Interpersonal skills of staff also played a role in how safe service users felt.

5.2.1.1 Being Informed

One participant explained that she always tries to find out as much information as possible before she is transferred.

- “I try to find out as much as I could about where I was supposed to be going before I say I would go” [P04]

Another participant discussed her experiences of being admitted to hospital.

- “On that admissions ward they’re so busy they don’t have the time to come say to you every hour, every couple of hours that, ‘it shouldn’t be too much longer’, or, ‘it’s going to be a while’. Really just to keep you informed.” [P13]

P15 discussed an incident that spans the two themes of communication and responsiveness; informing service users and responding to individual needs.

- “[The doctor] looked in my eye, and said ‘well you’ll have to go to the eye infirmary’ [...] And I had to come home on my scooter. I had to get a taxi. Aha. And when I got there, you’ll never guess. They were shut. They closed at half past four. [...] And that was a bad experience. Didn’t feel very safe then.” [P15]

5.2.1.2 Knowing that Support is in Place

When service users are discharged home, it is often the case that they will require additional support in order to help them cope. This can be seen by the use of the term ‘nothing to fear’ by participant 5.

- “Safe when I’ve been transferred? Well if the organisations are in place, I haven’t got anything to fear” [P05]

Later in the interview the same participant explains one of the systems in place for her care team after she has been discharged from hospital.

- “they can key in [a] code and get the key out to open the door and come in just in case of emergencies if I didn’t answer or anything like that... Just an extra protection sort of isn’t it?” [P05]

5.2.1.3 Having a Means to Contact a Healthcare Professional

Service users also discussed the importance of having a means with which to contact healthcare professionals once they are discharged.

- “when I say I feel safe, I feel safe with them there so I can call them at any time, the rapid response team. You know, it gives you that feeling of somebody’s there for you” [P15]

This also applies on a more immediate level that covers the use of personal alarms as a means to request help.

- “They’ve tied the... wall thing on here for me [personal alarm / call button]. Just having that beside you makes me feel a lot safer.” [P11]

5.2.1.4 Apologising

One participant when discussing an incident where the healthcare professionals hadn’t informed her that she was being discharged explained that either an apology or an attempt to view the situation from her standpoint would have stopped her from being annoyed.

- “I was furious. I was annoyed. [...] nobody said well we’re very sorry. I mean not that I wanted them to go down on bended knee and beg pardon, but they never looked at it from my point of view.” [P04]

5.2.1.5 Interpersonal Skills

There are many interpersonal skills that healthcare professionals have that make service users feel safe. These were identified by the participants as having the ability to put you at ease, being civil

- “you do feel safe when you’re leaving your home if you’re with these people. It’s not as if they’re a stranger to you, they actually put you at your ease so [they] make you feel safe.” [P08]
- “Well they were very civil, and when you’re old people are not always civil.” [P07]

Research notes taken from the interview with P02 further demonstrate the role that good interpersonal skills can have on how safe people feel

- ‘They talk to you, ask questions, ask how the pain is. It’s very nice to ask if you’re alright. This definitely helped to make you feel safe.’ [P02 interview notes]

5.2.2 Responsiveness

Another key theme that was identified when discovering what made service users feel safe and envisaging what would make them feel safe in the future centres around the responsiveness of the healthcare professionals, particularly in providing patient-centred care. As with communication, responsiveness is also a multi-faceted theme, with an emphasis on responding to individual needs, having short waiting times both on admission to hospital and when waiting for their healthcare professionals.

5.2.2.1 Responding to Individual Needs

Service users discussed how healthcare professionals could make them feel safer by responding to their individual needs.

- “I felt that they felt ‘there’s nothing wrong with her’ [...] they didn’t even open the back door. [...] And bearing in mind I hadn’t a breath in me. And they’re saying ‘go on you can do it, go on you can do it’. Like you know, and I did, but when I got in he had to put an oxygen mask on me” [P15]
- “I think you’d need to look at your patient first and decide whether they needed semi-personal attention, not total attention, put somebody with an eye on them” [P04]

5.2.2.2 Short Waiting Times

A further feature of providing responsive care that made service users feel safe included the length of the waiting times both after they had been transferred to hospital and discharged into the care of community care teams. Participant 13 is envisaging what would make her feel safer in future care transfers.

- “Could be to ensure that you were seen by someone straight away, you weren’t just left on one of those trolley things for hours which you can be. And being seen by, by the doctors quicker then a lot of the times you do, [...] I don’t want to be left on one of those trolleys, and I don’t want to have to wait hours to see a doctor.” [P13]
- “They’ll come to here if I need them. [...] I mean they’re not very long coming either, they’ll give you a time, ‘we’ll be there in thirty minutes’ or something. [P15]

5.2.3 Traditional Safety Issues

Participants described traditional safety issues whilst talking about safety, which for the most part consisted of falls, while there were also mentions of healthcare acquired infections (HCAIs), drug incidents, missed diagnosis and inadequate care.

5.2.3.1 Falls

The major issue that was discussed was being safe from falls when being transferred.

- “Being secure[...] know that if they try to lift you or anything that you’re safe and they won’t let you fall” [P01]
- “They help me down backwards, as I say down the step. One at either side they make sure I’m not going to fall. Oh no they’re very careful like that. I was safe.” [P04]
- “If I need help, if I fall[...] they get help to you” [P06]
- “there’s no fear of them tipping you up or anything like that. Safety wise, you know. Even in the ambulance, when you get in the ambulance everything’s[...] perfect” [P08]

5.2.3.2 Healthcare Acquired Infections

Participants also mentioned HCAIs, with two of the participants having acquired MRSA previously.

- “I just don’t like hospitals because I think all the bugs that’s going around that you can pick up, I’d rather be at home because I could pick up any of the nasty things there [at hospital]” [P06]
- “when I was there they kindly donated me the MRSA bug, and I had to stay in hospital for quite a while” [P07]

5.2.3.3 Drug Incidents

One participant in particular explained feeling unsafe once he had been transferred home due to his drug management method.

- “I don’t feel safe in the house now because I’ve been taking epileptic fits[...] I can’t remember what tablets I’ve got to take or when I’ve got to take them. And if I’ve took them, have I took them?” [P11]

5.2.3.4 Missed Diagnosis

Another safety issue that was discussed by a family friend of a service user was that of a missed diagnosis.

- “you had your x-ray and they said everything was fine[...] the nurse or somebody helped [daughter] to put her in the car, and she was yelping with the pain[...] they took her back to A and E only to find when she’d had that fall three weeks previous, she’d broke her hip” [P04]

5.2.3.5 Inadequate Care

The final traditional safety issue was being discharged without an appropriate care package in place.

- “I don’t think it should happen to anyone that is incapable of looking after themselves, to be sent home on their own to an empty house without any care support in.” [P06]

5.2.4 Attitudes Towards and Perceptions of Safety

In addition to the key themes that were identified, a number of related themes kept arising that could not be placed within the same categories. The most prominent of these was the issue of trust, which had an impact upon how safe patients felt. However where it differs from the other themes is that trust is not informed by individual acts but is created in a holistic manner encompassing all aspects of healthcare. A further theme that presented itself was that of power, which is of importance within an organisational development study.

5.2.4.1 Trust

Trust is a concept that frequently arose during the interviews when speaking with participants about what made them feel safe. Generally participants spoke about feeling safe because they trusted their respective healthcare professionals; however participants were also prepared to justify staff actions when things had gone wrong, instead placing blame on organisational restrictions.

Trust of Healthcare Professionals

- “you’ve got men and women doing their job and they’re there to look after you, and their training comes in [clicks fingers]. Safety first.” [P08]

- “I think that when you’re poorly you’re at your lowest ebb. And the reassurance in knowing that you have trained people with you, yes that does make you feel safe.” [P10]

Trust from Within

- “Being safe as I say, it’s just something that I assume. I mean, I presume I’m in capable hands, I presume they’re capable people that will get me from A to B in a comfortable manner” [P09]

Making Excuses for Healthcare Providers and Professionals

- “I seemed to be in this cubicle for an awful long time [...] But they were busy, they had emergencies and everything.” [P03]
- “I’ve seen it be half past eleven at night before you’ve got a bed in hospital, but that’s due to bed shortages and one thing and another. Everybody has to put up with that.” [P06]
- “I think they do as much as they can with the resources that they have. I don’t think they could do any more really.” [P13]

5.2.4.2 Attitudes to Safety

When participants were asked if they often thought about their own safety when going through an organisational care transfer, the majority stated that it was not something that they often thought about. The main reasons for these were that they either trusted the healthcare professionals to look after them, or because they were too ill to think about safety.

- “[Safety] never enters my mind. I just put myself in their hands. I know that they’ll get me there safely. I don’t know why, I just trust people.” [P02]
- “No, [safety] never has [entered my mind]. Probably because I feel safe, I don’t feel at all unsafe” [P10]
- “I’m always unhappy if I have to go into hospital, and when you go in you’re just not well enough to think about [safety]” [P11]

There were occasions when participants stated that they would think about safety. In the first example, it is dependent upon how ill he is. In the second example, safety is a concern due to the complicated nature of her treatment and the potential impact it could have if something

was to go wrong. She is discussing if safety crosses her mind when being discharged from hospital.

- “[...] if you’re being transferred and you are aware of everything that’s going on, then you may think about safety. But not when you’re poorly you don’t bother thinking about it. When you’re poorly that’s it. You’re being poorly.” [P09]
- “[...] safety becomes an issue if for example before I had the oxygen in, if I had difficulty breathing, well obviously I used the nebulizer and everything... so safety does cross your mind because if you haven’t got those things available to you, then things just get progressively worse.” [P13]

5.2.4.3 Attitudes to the Reporting of Safety

Participants reported mixed feelings towards the reporting of safety in response to the question ‘do you think there should be a means for you to feedback being safe or unsafe?’ There were a number of reasons for this mixed attitude, with those in favour of reporting seeing it as a learning experience for healthcare professionals, and to make them aware of any concerns. This tended to be focused around providing immediate, verbal feedback to the healthcare professionals.

- “if you’re nervous, if you feel unsafe I think you should be able to tell them” [P04]
- “if you’re being transferred you are then in the hands of somebody else. So there should be someone there in reasonably near contact, that you could either go to, speak to or something like that, if you felt either safe or unsafe” [P09]
- “Oh yes, I would certainly [feedback]... I mean the thing is I suppose it would help the paramedics if you were to tell someone that they were very good, that you felt completely safe.” [P10]
- “Yeah if there was a formal way [I would give feedback], if there was some form or something to fill in or something like that.” [P15]

Those that were against the reporting of their safety tended to state that they had never had a reason to report something, and so could not see the value in doing so.

- “It never bothered me [reporting safety], I just felt that of course you’ll be safe, that’s what they’re there for” [P01]
- “No I’ve not had any reason to [feedback]. I’ve never had any reason to, you know. I’ve always felt safe.” [P08]
- “Well if I felt unsafe I would probably complain, but as I say I’ve never faced that” [P10]

5.2.5 Summary of the Findings

In summary of the findings, there are a number of clear concepts that began to emerge when participants were discussing their safety in organisational care transfers. These have been merged into three key themes that demonstrate how the participants define and perceive safety when going through an organisational care transfer. In addition to these three key themes, there are also other issues that were of importance to the study, although they were not part of the original aims of this stage of the research. These include the role that trust plays in relation to how patients perceive and define safety, and participant attitudes towards safety and the reporting of safety. Table 5.1 presents a brief overview of these themes and sub-themes. Where possible the major themes are displayed down their second sub-theme.

Major Themes	Sub-theme 1	Sub-theme 2
• Communication	• Apologising	
	• Being informed	• Able to understand instructions • Kept updated • health care professionals identifying themselves • Know support is in place
	• Being friendly and Reassuring	• Civil and respectful • Having somebody to talk to
	• Listening	• Having a choice
	• Having a means to contact health care professionals	• Contact details • Personal alarm
• Responsiveness	• Easy process	• Support in place before transfer
	• Individual needs	• Co-operative
	• Listening	• Having a choice
	• Short waiting times	• Kept updated • Delayed response
• Traditional safety issues	• Adequate care	• Beds being made • Delayed response • Given food • Support in place before transfer
	• Falls	
	• Healthcare Acquired Infections (HCAIs)	
	• Medication	
	• Missed diagnosis	

	<ul style="list-style-type: none"> • Painful procedures • Physical safety 	<ul style="list-style-type: none"> • Able to breathe • Careful driving • Crowded waiting rooms • Personal security
• Trust	<ul style="list-style-type: none"> • From within • Make excuses for health care professionals • Trust in health care professionals 	<ul style="list-style-type: none"> • Religion • Busy • Lack of resources • In somebody else's hands • Training
• Attitudes to Safety	<ul style="list-style-type: none"> • Don't think about safety • Think about safety 	<ul style="list-style-type: none"> • Trust people • Don't feel well enough • Depending on illness • Depending on available equipment
• Attitudes to the Reporting of Safety	<ul style="list-style-type: none"> • (Discover) Had no reason to report safety • (Dream) Reporting can be useful 	<ul style="list-style-type: none"> • Make health care professionals aware of concerns • Provide helpful feedback

Table 5.1: Key themes of how participants perceive safety within organisational care transfers.

5.2.6 Reflections on the Data Collection Process and Analysis

Participants often struggled to understand the questions regarding the care transfer; they found it difficult to conceptualise which area of their care that I wanted to ask them about. This occurred from the outset of data collection, as notes from my research diary explain in relation to P01:

- ‘She appeared to struggle to grasp the concept of the care transfer. She appeared to want to keep returning to the idea of a care transfer being a local process, i.e. moving from her bed to the wheelchair.’ [JS Research Diary]

As this was a common trend amongst the interviews, attempts were made to try and establish as early as was possible what was meant by an organisational care transfer. As part of the interview briefing with the participant where the purpose of the study was explained, and they were also informed what was meant by an organisational care transfer. At the start of data collection this explanation indicated that an organisational care transfer is

when people were moving from one organisation to another. However this still caused some confusion with participants and on reflection did not detail the boundaries of the organisational care transfer, such as giving a specific start and end point. It was therefore decided that the boundaries would consist of any aspects of their care related to discharge or departing (such as planning the transfer), the journey itself and any aspects of their care related to admission or arrival (such as finding a bed). The latter of these appeared more complicated, and when asked by participants it was described as ‘up until the point at which they are settled’.

Despite this greater clarity, some participants had a tendency to move away from talking about organisational care transfers to talking about their care in general. This can be interpreted as part of the person’s narrative of their healthcare where it will include different modes and situations, and the separating of the organisational care transfer from the rest of the episode of care may seem artificial. The researcher selected the parts of this narrative that are of relevance to the study, i.e. those that focus on organisational care transfers. The aspects of care not related to organisational care transfers were left out of the analysis process unless deemed important to the transfer process in some form.

5.2.6.1 Dyadic Interviews

The uses of dyadic interviews have been argued to have both a positive and negative influence upon the interview process (Kendall, et al., 2009). Within this study the impact of using dyadic interviews was generally positive, where the family member or friend played a role in aiding memory recall or articulating in a clearer manner what was trying to be said. For example P04 was often reminded of particular situations or details that she would not have otherwise remembered, such as who was present during the transfer and when it was.

- Int “So did your daughter manage to get up for the Wednesday?”
- P04 “No she didn’t, no. She didn’t get up in time did she?”
- Carer “She did”
- P04 “Oh she did, yes”
- Carer “She did on the Wednesday. She couldn’t on the Tuesday because she was in London”
- P04 “They decided they would move it to the Wednesday”
- Carer “Half past four on the Wednesday I think”
- P04 “That’s right, because she couldn’t leave [work], and that was more important.”

P08's wife helped him to articulate his feelings, often referring to P08's experiences as joint experiences through the use of the word 'we'.

- P08 "My wife's explained to you what I've tried to put into words"
- Wife "I don't know, I still can't do it properly, but if that's the way it comes across, that's the only way that [P08], I mean me would be able to explain that"
- P08 "I've never had any bother"
- Wife "Never felt insecure"
- P08 "Insecure or anything off the paramedics. They've always been gentlemen"
- [...]
- Wife "If that helps, but that's the only way we could put it that way. It's the only way we could feel to put it in that category."

Although it could be argued that these do not make up the individual's own interpretation, in both circumstances the family friend or member was present during the transfer, and their input into the interview was supported by the research participant. It did not appear that they were influencing or changing the participant's own perspectives, but instead supporting and expanding upon them. Kendall et al. (2009) highlight that multiperspective data can sometimes show differing concerns amongst participants, but there were no instances of competing ideas or perspectives during the dyadic interviews in this study.

5.3 Discussion of the Findings

The following section aims to give an overview of the research findings from Phase 1 of this study, with a particular emphasis on how this impacted upon the research process of Phase 2. In order to do this, it is first necessary to explore how these findings relate to the philosophical assumptions of both phases of the study, and the implications that these findings have for Phase 2. A wider discussion of these findings is presented in Chapter 8.

5.3.1 Relation to the Philosophical Framework

The findings from this phase introduce the role of interpretivism into patient safety which is usually investigated through a realist medical framework. By linking back in with the critical realist framework of this study, the findings represent the individual interpretations of patient safety that the patients interviewed held. As has been highlighted, these differ slightly to those of healthcare professionals, although there is still some overlap in the form of 'traditional safety risks'. When interpreting the single reality, these differences and similarities are to be expected as there will usually be an overlap between different groups of

individuals. However with regards to this study the differences in interpretations are of greater importance, as those that are the same will already be included in current reporting mechanisms aimed at those that are able to identify them, such as healthcare professionals reporting falls, medication errors and healthcare acquired infections.

Therefore these different interpretations of reality emphasise the need for a patient reporting mechanism for safety. As patients interpret reality differently to healthcare professionals, they are thus perceiving a different part (or depth) of that reality. There is a need for the mechanism to be capable of capturing this intransitive nature of reality, otherwise safety is not explored, challenged and addressed in every possible way, but only in a manner of relevance to (or via interpretations from) healthcare professionals. Additionally, through the process of retroduction, the findings have been used to identify the potentially underlying mechanisms that are able to produce the safety in the form of the safety buffers in the Swiss-Cheese model of safety. Theories and models of safety are discussed in Chapter 8.

5.3.2 Implications for Phase 2

The original plan for the study was that findings from Phase 1 would inform the development of the reporting mechanism. It was therefore essential that these findings were conveyed throughout the entire research process, so that the reporting mechanism would capture these perceptions and not focus specifically on traditional definitions of safety. For this reason, the findings from Phase 1 were reported to all healthcare professionals involved in the recruitment of participants, with the intention that they would then be involved in the development of the reporting tool, and that they understood that it would be developed based upon these findings.

It was therefore essential that the reporting mechanism to be developed and piloted in Phase 2 captured communication and responsiveness in addition to the traditional safety issues identified by participants. On a philosophical level, basing the reporting mechanism on these perceptions allows for the identification of the clear and consistent patterns of practice that were identified as being important in relation to the underlying causal mechanisms of safety (McEvoy & Richards, 2006). On a theoretical level, the perceptions have identified new safety buffers that can lead to increased safety, however there needs to be a mechanism to be able to identify when these buffers have failed.

A further impact of these findings upon the development and piloting of the reporting tool is the finding that there were mixed feelings towards safety and towards the reporting of safety,

which has also been identified previously (e.g. Davis, et al., 2007). It is therefore important for there to be an evaluation of the reporting tool so as to capture its perceived usefulness from participants. Furthermore as the definitions of safety are developed based on fourteen participants' perception of safety, there needs to be an opportunity for future participants to refine the definitions if they see something else as being important to their safety when going through organisational care transfers. Both the evaluation and further refinement will be detailed in greater depth in Chapter 7.

5.4 Chapter Summary

The findings presented in this chapter offer a different insight into safety than the medical definition which dominates the literature. There was some crossover between participants' perceptions of safety and the medical definition such as medication errors, HCAIs, but some large differences also exist. In particular, participants identified that different components of communication and responsiveness are important to their safety.

The following two chapters will explain the processes involved in the development of the reporting mechanism and how it was piloted and further refined. Each chapter will be presented individually, although there is inevitably some crossover between the two chapters and this, in particular in relation to the recruitment of the organisations.

This chapter has only given a brief discussion of the findings so that it is clear to the reader how they informed the development and piloting of the reporting tool. They are discussed in greater detail in the discussion chapter (Chapter 8), as well as an explanation of how they link into the wider literature on reporting of safety and other theoretical concepts.

Chapter 6: Development of a Patient Reporting Mechanism

6.1 Chapter Overview

This chapter details the processes by which the patient reporting tool was developed through two collaborative workshops, which formed the Design (Plan) stage of the first AR cycle. It begins with a reminder of the original aims for the reporting mechanism, and is then structured in terms of the methods, data analysis, findings and reflections of each workshop. This covers how the reporting mechanism was developed and the rationale for the inclusion of its individual components and the principles that underpin it. Although the involvement of the organisations began during the recruitment of participants in Phase 1, the collaboration between the organisations only came about in the two workshops.

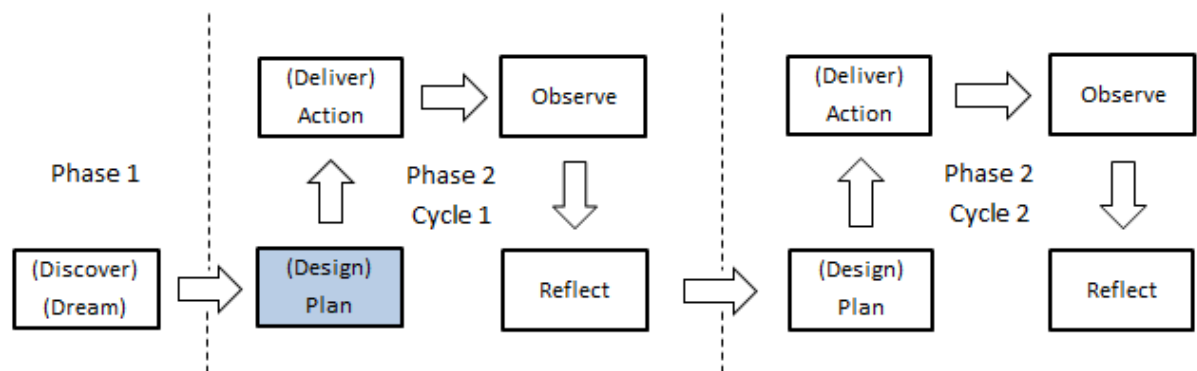


Figure 6.1: Where the development of the reporting mechanism fits into the methodological cycles (Phase 2 Cycle 1).

6.2 Aims of the Reporting Mechanism

The aim of Phase 2 was to develop a method of facilitating service users to identify and report self-defined safety incidents in an organisational care transfer setting. To achieve this, the aim was split into two objectives; develop a method of facilitating service users to identify self-defined safety and to create a mechanism for service users to report self-defined safety. The patient perceptions of safety identified in Phase 1 of the study; communication, responsiveness and traditional safety risks were embedded within these objectives. The AI methodology was reflected in the focus on safe care in addition to unsafe care.

6.2.1 Findings

6.2.1.1 Summary of the Findings

When exploring what the reporting mechanism should look like, participants were asked to focus on the format that it should take and what questions it should ask. During these discussions, key principles that underpin the reporting mechanism were also introduced. Potential designs that were identified for the reporting mechanism included service user meetings, generic open-ended questionnaires, one-to-one interviews, verbal reports, Patient Advice and Liaison service (using service user complaints) and leaflets. Out of these, participants felt that a questionnaire and / or a leaflet were the most appropriate method of capturing patient reports of safety. Key principles highlighted by participants were that the reporting mechanism needed to be patient-centred, short and concise with clear signposting, optionally anonymous and have a focus on both safe and unsafe care.

Participants also explored practical issues of implementing the reporting mechanism in that it needed to comply with current processes that are already in existence within each of the services. It was identified that there are already numerous feedback mechanisms for when care is already in place, but there are no mechanisms for the admission and discharge processes within the organisations represented in this study. Discussions around the distribution of the mechanism focused on an individualistic approach in that it should be given to service users after each episode of healthcare. However there were uncertainties around if this should be via continuous distribution or batch distribution, depending upon available financial and time resources. It was felt that either local or national legislation would be necessary as a driver to implement the reporting mechanism on a wider scale, with funding issues focusing on any potential advertising of the reporting mechanism and a sustained roll-out. The final issue of implementing the reporting mechanism discussed by participants was who the responsibility for monitoring and acting upon the reports rested with. The workshop did not provide solutions to these issues, which would need to be addressed if a patient reporting mechanism was introduced into practice.

6.2.1.2 What will the Mechanism Look Like?

This question was split into two parts that were addressed at the same time by the participants; 'What format will the mechanism take?' and 'What questions will it ask?'. The following analysis is structured in terms of the two sub-questions and cues given to participants in Workshop 1 (Table 4.3). A further section is included on the principles that participants felt were needed to underpin the reporting mechanism.

What Format will the Mechanism Take?

A number of suggestions were proposed by the participants as to what format the mechanism would take. These captured a wide variety of methods that patients could report safety back to their healthcare professionals. Below are the proposed formats of a reporting mechanism provided by Group 2 via flipchart paper, though there is no relevance to the order in which they are reported. Group 1 held a different discussion to Group 2, instead focusing on the principles of the reporting mechanism and what healthcare professionals and service users would want in a reporting mechanism. During this discourse, methods of reporting were also discussed and are combined with those provided by Group 2. There were no unique methods proposed by Group 1 that were not also identified by Group 2.

- Service user meetings in different locations

Flipchart paper notes and the observation of Group 2 suggested that service user meetings could either take a similar format to, or be linked in with current Local Involvement Networks (LINKs), where service users would have the opportunity to discuss any safety issues amongst each other and with healthcare professionals.

- Surveys

Both generic questionnaires and leaflets were suggested by participants as appropriate means of collecting service user reports of safety via surveys. Within these, different methods of conducting them were suggested, which included via postal services and one-to-one guidance.

One of the key requirements of using a survey was that it would need to be generic so that it could be applied to any service, which was particularly important as service users could be being transferred to and from many different organisations.

- “it’s easiest and most generalisable thing isn’t it? Especially for covering the range of services. [...] There needs to be somebody who can come back to all these different points in the process. [...] It’s got to be very general I think is what I’m trying to say.” [SCHM, Group 1]
- “I know what you’re trying to say, you’re trying to say something generic for the whole of any service, on a transfer of care. But I think that’s because transfers of care are that different to talking from somebody being transferred from a home to a hospital, a hospital to a home, for an appointment, for going for an x-ray” [CCTN, Group 1]
- “Coming in on their own steam...” [SCHM, Group 1]

- Verbal reports

The EP in Group 1 described that from his own personal experience he would have liked to have provided verbal feedback, either face-to-face or via the telephone

- “In regards to that situation that you were saying, [...] from this mechanism would you say that it was better to speak to somebody verbally or was it better to be done face-to-face or over the telephone, or...? [CCTN, Group 1]
- “I would have quite happily done it face-to-face, or telephone would have sufficed” [EP, Group 1]
- “I’m going to put verbally there then [on the flip chart paper]” [CCTN, Group 1]
- “Aha” [EP, Group 1]

This method also received support from a healthcare professional later in the break-off session.

- “Patients are always encouraged, sort of if they do feel in any sort of way then they can contact us as first contact, and if they don’t feel that they’re getting any further forward then by all means contacts PALs. I would far rather try and sort of... if a patient was saying to me that they didn’t feel that something was safe, I would far rather try to sit down with the patient and try to sort of get to the bottom of what they felt. Because if it was just a case of misunderstanding then I could work with the patient to give them reassurance for that. But if there was a case that something was unsafe then ordinarily... our sort of reporting mechanism... it would take shape that way.” [CCTN, Group 1]

- PALs (complaints)

The Patient Advice and Liaison service (PALs) was suggested by an expert patient in Group 2:

- ‘If you have a reps group, how do you reach everyone – PALs – report an incident, want a response’ [PD observations, Group 2]

In response to the suggestion of using PALs data, the other expert patient in the group questioned ‘how do you know what’s happening outside the box?’, subsequently suggesting service user to service user interviews. These were not recorded on the flipchart paper, and there is no further reference to them in the observation notes.

Group 1 also discussed the use of PALs, in particular focusing on the limitations of utilising pre-existing data. PALs aims to stop people from making a complaint by resolving any

issues, subsequently making any complaints data unrepresentative, and potentially resulting in only 5% of patients that are unhappy with their care going on to make a complaint (National Audit Office, 2008). Furthermore the EP in Group 1 recalled a time when he wanted to make a report about a transfer of a relative, and opted not to contact PALs:

- “But [PALs] is almost like putting in a complaint. I didn’t really want to put in a complaint, I just wanted to say is there a better way forward?” [EP, Group 1]

At the end of the workshop when participants were deciding which aspects were of greatest importance or relevance, six stars were placed on ‘generic questionnaire’ and five stars were placed on ‘leaflets’. No stars were placed on any of the other formats, signifying that the participants wanted the mechanism to take the form of a questionnaire and / or leaflet.

Principles that Underpin the Reporting Mechanism

Participants made recommendations and references to the principles on which the mechanism should be based. These included that it should be patient-centred, short, concise with clear signposting, optionally anonymous and being objective with a focus on both positive and negative care.

- Patient-centred

The SCHM in Group 1 referred to their processes being patient-centred, although there was no such process in place for admissions and discharge, which the reporting mechanism would be able to address.

- “Our whole assessment and care planning process is person-centred. So there’s lots of opportunities there for the person to have their say about the service we’re providing. Perhaps what we haven’t got is just before they get to us, and just after we discharge them.” [SCHM, Group 1]

- Short and concise with clear signposting

There was also an agreement that the reporting mechanism needed to be both short and open-ended so that service users could report what was of most importance to them, although the open-ended nature of the questions were not recorded on the flipchart paper.

- “From a professional wanting to know what a patient would want, you’d want something that’s short but open-ended...” [CCTN, Group 1]
- “Yes” [EP, Group 1]
- “... so it allows the patient to... discuss one aspect that you felt safe. That’s a massive topic but if you had sort of four or five questions like, were you happy with

that element of care?, did you find that was safe?, and that sort of thing” [CCTN, Group 1]

- “Yeah, and, if not, why not?” [EP, Group 1]

Participants felt that a short and concise reporting mechanism would increase the number of service users that completed it. This conversation also highlights what is meant by the term objective; that the mechanism needed to be equally weighted between safe and unsafe care.

- “So to capture that [transfers of care are different], would we say that they would want the questionnaire to be sort of short and concise to encourage people to actually do it?” [CCTN, Group 1]
- “Got to be fairly concise. The longer it is I think the less chance there is of getting involved with it, and especially if you’re asking for positive as well as negative feedback or just general commentary” [SCHM, Group 1]
- “That’s a very important point. It shouldn’t all be whinging. You need to capture the positives as well” [EP, Group 1]
- “So objective, yeah?” [CCTN, Group 1]
- “Yeah” [EP, Group 1]

- Unbiased

The use of the term unbiased was used by both health care professionals and Expert Patients to emphasise the necessity to be appreciative, which also corresponds with being objective. Both groups were aware that any reporting mechanism needed to place an emphasis upon both the positive and negative experiences of safety.

- “You don’t get much feedback unless it’s a complaint” [SCHM, Group 1]
- “But I think, I think a lot of people do get feedback. I just think there’s an emphasis on the negative. There’s a lot of people, like I’m sure you’ve probably had a patient, where they feedback that you do a grand job. That never gets captured.” [CCTN, Group 1]

- Anonymous (optional)

Participants felt that the reporting mechanism should have an option to be anonymous as some service users would want to avoid going through a formal complaints procedure. However there were concerns over the traceability of an incident.

- “The only problem is with it being anonymous is.... tracing it back because it’s actually more effective when you can look. [...] So you can improve practice

generally, but for that specific case you might want to look at it in more detail.”
[SCHM, Group 1]

What Questions will the Mechanism Ask?

The two groups took different approaches to tackling this question. Group 2 discussed the actual questions that the mechanism should ask service users, which included;

- How satisfied were you with the length of time taken for:
 - Ambulance
 - GP appointment
 - Hospital appointment
 - Treatment
 - Waiting time
 - Follow-up
 - Test results, etc.
- Did you feel your needs / requests were listened to / met / respected
- How satisfactory was the care you received? E.g. basic needs: food and drink / medical care
- Were you given contact numbers of services in the community?

However these questions do not deal with the issues of safety, either from a medical or service user perspective, suggesting participants struggled to differentiate between service user reporting of safety and service user reporting of satisfaction. This ties in closely with the findings of Kuzel et al. (2004), who found that by including emotional distress as a safety incident, the boundaries between patient safety and patient dissatisfaction were blurred. This has been further supported by Burroughs et al. (2005) who found that patient reporting of medical concerns was significantly correlated with patient satisfaction. Group 1 did not tackle the direct questions that would be asked, instead focusing on the principles behind the questions.

6.2.1.3 How will the Mechanism Fit with Current Systems?

A number of points of discussion arose during the second break-off session which focused on how the potential mechanism would fit with current mechanisms. These have been split into six themes; Current Systems, Distribution, Drivers, Financial Considerations, Timescales and Outcomes. Participants appeared unclear about the purpose being to develop a mechanism to allow service users to report safety incidents, and not satisfaction.

Because it has been highlighted in the literature (Burroughs, et al., 2005; Kuzel, et al., 2004) and was evident in Workshop 1 that it is difficult to distinguish between service user reporting of safety and satisfaction, it is assumed that the principles behind any reporting mechanism should be similar. The six themes also incorporate data from the first break-off session when participants diverged from the question and discussed issues pertinent to the implementation of the reporting mechanism.

Current Systems

Participants were unsure about what systems were available locally and nationally that the mechanism could link into. This was especially the case for the EP in Group 1 who acknowledged that service users are often unaware of the systems in operation.

- “I know some of the current system, but... for the service user that could be the problem, you don't maybe know the system. I mean, I know part of the system” [EP, Group 1]

A further question was raised about how well the current systems (such as PALs, complaints and patient satisfaction surveys) work, and if they don't work, then it was unclear what purpose fitting the mechanism into it would serve. It is possible that this was a result of the participants focusing on developing a patient satisfaction survey, and not a patient safety reporting mechanism. However these questions are still valid and were addressed when developing the mechanism, although this was done within the context of patient safety reporting mechanisms and not patient satisfaction surveys. The final comment regarding the current systems was that the mechanism should complement existing services.

- “From our perspective we've already got lots of things in place where service users can give feedback, not just complaints. So one of the first considerations for us is to not duplicate what is already there.” [SCHM, Group 1]
- “Our whole assessment and care planning process is person-centred. So there's lots of opportunities there for the person to have their say about the service we're providing. Perhaps what we haven't got is just before they get to us, and just after we discharge them.” [SCHM, Group 1]
- We've all got process in place that if there's something we're concerned about we can bring it up. But looking what feedback we get from patients, I know certainly on

an ambulance point of view, we get no feedback. The only feedback we get is either a complaint coming in or a letter of thanks. [ASP, Group 1]

An additional concern raised was how the reporting mechanism would be regarded by governing bodies that had their own systems in place to monitor adverse events.

- “if there’s suddenly another pathway comes in for people to put in negative feedback, how are they going to... I don’t know how that would be seen not just by our governing bodies but other governing bodies that are already in place” [ASP, Group 1]

When discussing how the reporting mechanism would fit with current systems, participants returned to the notion that a generic reporting mechanism could be applied regardless of the point of care in which service users were to receive it.

- “a very generic form which is available at all points of care; it’s available in the care homes, in the ambulance, in the hospital, in the doctors’ surgery. The same thing is available right the way through, so wherever you are, whatever point in the care pathway you’re at, whoever you’re talking to, you’ve got the same pathway to give feedback” [ASP, Group 1]

Distribution

Distribution of the mechanism focused on when service users would be given the mechanism and the timescales involved. Firstly, it was suggested by Group 1 that service users are given the mechanism post-consultation. This was further developed with the suggestion on the flipchart paper that ‘each mechanism captured after each [...] consultation’. Three stickers were applied denoting the importance to the participants.

Concerns were raised regarding the number of times service users were to be asked to complete feedback forms during or shortly after organisational care transfers.

- “what we get is people who’ve been in hospital perhaps, then they’ve come into us, then they’ve maybe gone back into hospital and then come back into us again. So what they’ll have done within that, they’ll have gone through lots of assessments and answered loads of questions, and be assessed to death[...] so you get a lot of service users who are sick of being asked questions” [SCHM, Group 1]

Secondly, two different timescales were suggested for distributing the mechanism. This included continuous distribution, whereby potential respondents would be given the

mechanism on a continuous basis where certain criteria were met, although these criteria were not established during the workshop. The other option was to conduct a batch distribution of the mechanism. Each has their own merits; continuous distribution would allow for a more responsive service that captures instances of safe and unsafe care in real-time, whereas batch distribution would be more time- and cost-effective. Both distribution techniques will have to be considered in further depth before a decision is made.

Multiple methods of feedback were supported as a means of capturing as many experiences as possible. One particular outcome that can be inferred from this is that any reporting mechanism should enable as many people as possible to complete it by taking into consideration any barriers that may affect them; in this scenario a questionnaire can be used to overcome the barrier of being unwilling to speak in front of a group of service users about any issues that are of a concern.

- “In our service if we’re trying to encourage as much feedback as possible what we try and do is we try and have a range of routes that people can go down. So you might have people who are unhappy about speaking up in a group, but we have a service user meeting every week so you know that that person may not want to speak up in a group, that’s fine. That person has then got the option of filling out a questionnaire... or other people have got access to a comments and complaints box. So is it about having a range of options when you’re signposting ways of reporting? So you can do that, that or that.” [SCHM, Group 1]

Drivers

Two key drivers were discussed regarding the implementation of a reporting mechanism; will it be driven by legislation and/or will it be incorporated into operational policy, and the role of partnership working. The issue of legislation and/or operational policy is difficult to address due to the changing nature of healthcare services at present as a result of the recently published white paper, *Equity and Excellence: Liberating the NHS* (Department of Health, 2010a). It is assumed that during the initial piloting of the mechanism, the driver will be the participants’ desire to improve patient safety within their organisation.

Partnership working was also mentioned as a necessity when working across boundaries. This has already been identified in the literature in terms of interprofessional collaborations (Berg-Weger & Schneider, 1998; Bronstein, 2003) and the positive impact that they can have on services (Ponte, et al., 2010); however it reaffirms this need to work closely with different organisations when service users are undergoing an organisational care transfer

and suggests that the participants involved in this study are keen to improve their services in this area.

Financial Considerations

Relatively few financial considerations were mentioned. Of those that were, marketing of the mechanism received the greatest attention. This focused on how service users would find out about the mechanism, with a suggestion that advertising and awareness campaigns should be initiated to increase awareness. Although this was proposed by the EPs in Group 2, there was little support from the healthcare professionals

- '[EP 1] Whatever method the service user needs to be aware of this'
- '[EP 1 and 2] Mass marketing and advertising for LINKs; didn't yield any response' [PD observation notes, Group 2]

- '[EP 1] got to be marketed to the service user. They won't ask for it for fear of discrimination' [PD observation notes, Group 2]

Due to the nature of the study and the funding streams, it was not possible to market the mechanism unless the organisations took this on themselves. During the piloting stages, the relevant participants from the workshop will make their service users aware of the mechanism.

The other financial consideration was where the funds would come from to deliver the mechanism over a sustained period of time. Again this would need to be developed further within each of the participants' own organisations, and is closely linked with the distribution techniques. It may therefore be viable for organisations with greater financial constraints to use batch distribution methods.

Measuring Outcomes

This theme focuses on how the outcomes of the mechanism were to be measured. It arose after discussions focused on what would happen once a service user had completed the mechanism.

Group 2 also focused on the perceived outcomes of the reporting mechanism, though with a particular focus on the impact that it may have upon practice. In particular it is highlighted that there needs to be an incentive to improve safety.

- [ASP] this is an exercise in seeing where the problems lie – but what is done and what is the impact? [PD observation notes, Group 2]
- [ASP] nothing will happen unless there's an incentive to drive up performance [PD observation notes, Group 2]

Suggestions were put forward that healthcare professionals should monitor the outcomes and feedback to the service users the results of the report.

- “I think you also need to let service users know what will happen to the information because that's the next stage...” [SCHM, Group 1]
- “There's nothing worse than putting in a report and it disappears.” [EP, Group 1]

It wasn't discussed what feedback should be provided to service users, though this should be identified through current literature. A study exploring service user involvement in the planning and delivery of mental health services found that service users were dissatisfied when feedback was not provided following consultation with them (Crawford, et al., 2003).

In addition to these outcomes, it was felt that giving service users the opportunity to report on their concerns and worries about their safety helps to break down barriers between the healthcare professional and the service user. This was partially supported by a healthcare professional in the group, with the added caveat that for this to occur patients needed time to digest information and to develop their thoughts and feelings.

- “If you ask a patient if they have any concerns or worries that's a huge... it breaks down barriers” [EP, Group 1]
- “I semi agree with that for the simple reason that I've witnessed patients being offered all this information and it's not until the doctor gets up and leaves and they go 'ohh', and it's that time afterwards where... so they probably do want to ask the questions but I think it's allowing... giving them the information and giving them time to think about it and to develop their thoughts and feelings” [CCTN, Group 1]

6.2.2 Reflections of Workshop 1

The development of the reporting mechanism was an iterative process which began with Workshop 1, and continued over the course of Workshop 2 and the two cycles of piloting. Workshop 1 provided the opportunity to explore a potential reporting mechanism whilst providing the foundations for the further development in Workshop 2. This section provides a reflective account of Workshop 1 and explains how the data was used to inform the development of Workshop 2. A summary of these reflections is provided in Table 6.1.

6.2.2.1 Patient Satisfaction

One reflection that was evident to both the researcher and an observer (PD) was that participants appeared to struggle to grasp the concept of developing a mechanism for service users to report safety incidents. Instead they appeared to be intent on developing a patient satisfaction mechanism. This was first evident when participants were discussing the current systems that already exist. Although they identified some systems that are available to report safety, such as complaints mechanisms, they also discussed patient satisfaction and experience questionnaires that are already given to service users during their episode of healthcare.

- ‘I had to prompt when group got bogged down with designing a patient satisfaction questionnaire’ [PD observation notes, Group 2]

When discussing what the mechanism may look like, participants used language that was synonymous with that of patient satisfaction. For example, when Group 1 discussed the use of an open-ended questionnaire as a possible reporting mechanism they often used the word ‘like’.

- “if there’s one fairly generic open-ended sheet with how do you rate this, how would you feel safe, blah blah blah. That would give you the option as a user at any stage to say right, I’ll have one of them. I like that and didn’t like that.” [ASP, Group 1]

This reflects other research that identified there is a very fine line between patients reporting safety incidents and patient satisfaction (Burroughs, et al., 2005; Jha, et al., 2010; Kuzel, et al., 2004), which in this study is seen in both EPs and health care professionals. Although this may be somewhat understandable in health care professionals, by definition EPs can operate in a similar paradigm. It is possible that this was the cause of the lack of the development of a tangible reporting mechanism on which to build in Workshop 2. Given that participants were informed that the mechanism needed to include issues relevant to service users identified in Phase 1 of this study, it is understandable why participants hadn’t stated what questions the mechanism should ask as the instructions at the outset could have been more direct.

6.2.2.2 Individual Agendas

When working in a collaborative environment it was necessary to reflect upon and take into account the personal and individual agendas participants brought with them, in order to address how these agendas could be constrained during Workshop 2.

During Workshop 1 it was evident that some of the EPs wanted to tell their stories even when they were not always relevant to the task in hand. This agenda was clear early in group 1, where the expert patient stated:

- “[I] have a story to tell which fits quite neatly into some of the things that Jason outlined [in the introduction]” [EP, Group 1]

When the EP asked if he could recount his experiences of going through a care transfer, I tried to address this as there were tight time constraints on the workshop. Although this supports the findings from Phase 1 and could have provided a useful link between Phase 1 and Phase 2, it detracted from the focus on the development of the reporting mechanism.

- “Would it be useful if I gave you the real life scenario which involves the ambulance service, care home and hospital. Because I’ve got some unanswered question, and it’s real. Do you want to start at that...” [EP, Group 1]
- “The thing that I’m concerned about is the time we’ve got and the amount of stuff we need to get through [...]” [JS, Facilitator]

However this did not work and the EP insisted on telling his story so that he could try to obtain answers to these ‘unanswered questions’. This posed a problem, as it had the potential to cause the healthcare professionals in the group to become defensive, as the use of the term ‘unanswered question’ could be seen to be confrontational. Furthermore, the telling of these stories impacted upon the time available to discuss the issues that were of most pertinence to the development of the reporting mechanism. Williamson (2007) identifies that EPs are able to speak for patients’ interests in the same manner that health care professionals speak for their own interests, which is evidently what was happening within this workshop through the telling of their own stories.

Health care professionals may also have brought with them their own agendas. The greatest threat to the study and to the collaborative nature of the AR methodology was that the health care professionals were not receptive to the idea of patients reporting on their safety, which would suggest that their attendance was in defence to any mechanisms and to guide it away from the patient reporting of safety. Although this could be perceived to be a reason for the

focus on patient reporting of satisfaction rather than safety, the discussions between participants suggested that they wanted to receive truthful feedback from participants.

- “You want them to be honest really” [CCTN, Group 1]
- “You do want people to comment about your service don’t you? You don’t want people not to give feedback about, you know, what you’re doing because you need to know that it’s... okay, and safe.” [SCHM, Group 1]

There was one technical issue encountered during Workshop 1, where the voice recorder did not start. This meant that the intricate discussions that were going on in Group 2 were not captured.

Reflections	Impact on Workshop 2
Participants focused on the reporting of patient satisfaction instead of the reporting of patient safety, despite being briefed before and during Workshop 1	Repeat the emphasis of what we are trying to do, but clarify what it is that we do not want participants to do.
Lack of the development of a tangible reporting tool	Different methods will be utilised that will focus participants on the development of the reporting mechanism based upon the principles highlighted in Workshop 1.
Personal and professional agendas may have a negative effect upon the group discussions	More direction given to participants as to what is wanted will help to guide the discussions. Moving away from the principles of a reporting mechanism to the physical development will help provide this direction. Familiarity with fellow participants will also help to reduce this.

Table 6.1: Reflections on Workshop 1 and the impact upon Workshop 2.

6.3 Workshop 2

Workshop 2 is presented in terms of the recruitment of participants to the workshop, including how they were chosen and the group constitution within the workshop. The methods of data collection within the workshop are explained, followed by the ethical considerations and how the workshop was structured. Finally the data analysis, findings and a reflection of the findings are presented.

6.3.1 Findings

The findings are presented in relation to the outcome of the workshop; the mechanism for patients to report their safety. Although the processes of divergent thinking opened up many different ideas for the reporting mechanism, only those that contributed to the final idea are included. The data to support these are presented in terms of the decision to use a leaflet as the reporting mechanism, and then the twelve individual sections that construct the final reporting mechanism. Other concepts that were not important to the development of the reporting mechanism are provided as a summary. The findings are not reported in chronological order based upon the point at which they were discussed, but instead tell the story of how the final design of the reporting mechanism was developed.

6.3.1.1 Choice of the Reporting Mechanism

During the divergent thinking session a number of ideas were generated, which are listed in Table 6.2 along with the group they originated from and a brief explanation.

Idea	Group	Brief Explanation
Noticeboard	1	Provided in GP waiting rooms for patients to write comments about their recent experiences. Provides anonymity.
Postcard	1	Given to service users during every part of the journey to complete, capturing the wide range of organisational care transfers.
Post-boxes	1	An alternative to the noticeboard which provides privacy for service users and confidentiality for healthcare professionals.
Thermometer Scale	1	Service users are able to place stickers on a large thermometer relating to how safe or unsafe they felt. Proposed as it would be quick and easy for service users
Questionnaire	1	A simple questionnaire sent to service users post-transfer
Aviation Reporting Tool (CHIRP)	2	CHIRP is a tool used in aviation. Suggested as an idea as it is confidential and had no blame attributed to the reports.
RSPB Bird Watch	2	A method of collecting a lot of data in a systematic way over a short period of time
Gordon Ramsey	2	Communication in restaurants by waiters can reduce the impact that long waiting times have
Supermarket Tokens	2	System similar to supermarket charity donation tokens. Given to service users on discharge for them to place in a 'safe' or 'unsafe' box
Reverse Transfer	2	Increase safety by reducing the number of organisational

		care transfers through increased care in the community
Internet Questionnaire	2	An automatic email sent to everyone that had gone through an organisational care transfer
Hospital Wait	2	Provide information, either in person or via electronic screens regarding length of wait and delays
Discharge Lounge	2	Place for service users to go prior to a discharge to free up a bed. Somebody could be there to coordinate transfers, provide information and receive feedback

Table 6.2: Divergent thinking ideas for a patient reporting mechanism.

Group 1 decided that the postcard was the best system to take forward and develop due to its simplicity and applicability to a wide variety of settings. Group 2 chose to develop a leaflet-based reporting mechanism, split into three sections directed towards the discharge, journey and admission of the service user. Ideas from both groups were included in the reporting mechanism. The following section explains how each of these came together to form the mechanism.

1 What do we mean by safety?
Safety can have many different meanings. From speaking with other service users, we believe that to feel safe, healthcare professionals must:

- communicate with you,
- respond to your individual needs,
- ensure that you can trust them.

You should also be physically safe and secure, such as being free from:

- falls,
- healthcare acquired infections,
- medication errors.

2 What do we mean by your transfer?
Your transfer is an episode of healthcare when entering or exiting a health service. This includes planning and preparing for departure, the journey and settling in on arrival.

3 What to do if you want to make a complaint?
By completing this reporting tool you are **NOT** making a complaint. Instead we are going to use the information you have provided to improve services. **If you would like to make a formal complaint please contact the Patient Advice and Liaison (PALs) team on 0800 953 0667.**

4 Would you like to provide more information?
If you would like to provide explanations, please feel free to include them on an extra piece of paper. All feedback is welcomed and will help us to improve the safety of services.

5 Would you like to receive feedback?
Yes ☐ No ☐

If yes, please fill out your details below. All information will remain private and confidential in line with the Data Protection Act 1998, and will not be shared with anyone or used for any other purpose than to provide you feedback.

Name: _____

Address: _____

Telephone: _____

To find out if we are reaching everybody, could you please tell us your gender, age and racial / ethnic origin. You do not have to complete this part if you do not want to.

Gender: Male ☐ Female ☐

Age: _____

Racial / ethnic origin: _____

6 **SAFE AND SURE**
Patient Safety Survey

7 **SAFE AND SURE**
Patient Safety Survey

8 **SAFE AND SURE**
Patient Safety Survey

9 Dear patient / carer,
This form is for you to tell us if you felt safe or unsafe in your recent transfer, and what made you feel this way. Anything that you tell us will remain confidential and will not affect the care that you receive

It is important for us to capture your experiences so that we can improve our services. **Please complete the form and return it in the prepaid envelope provided.**

If you have any questions or would like help completing the form, contact Jason Scott on 0191 215 6722.

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Figure 6.2: Outside of the patient reporting mechanism v1. See Table 6.3 for where each section is reported in the chapter.

Date: _____ Location: _____ Your Departure Leaving point: (please tick) • Community Care <input type="checkbox"/> • Home <input type="checkbox"/> • Hospital <input type="checkbox"/> • Nursing / Residential Home <input type="checkbox"/> • Other: _____	Date: _____ Location: _____ Your Journey Method of transport: (please tick) • Ambulance <input type="checkbox"/> • Patient Transport <input type="checkbox"/> • Private Car <input type="checkbox"/> • Public Transport <input type="checkbox"/> • Taxi <input type="checkbox"/> • Other: _____	Date: _____ Location: _____ Your Arrival Destination: (please tick) • Community Care <input type="checkbox"/> • Home <input type="checkbox"/> • Hospital <input type="checkbox"/> • Nursing / Residential Home <input type="checkbox"/> • Other: _____																		
Please tick which of the following affected how safe or unsafe you felt during your departure, including the preparation and planning. Communication from staff <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Staff listening to you <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Departure running to schedule <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Falling or potential falls <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Medication problems or concerns <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hygiene <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please tick which of the following affected how safe or unsafe you felt during your journey. Communication from staff <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Staff listening to you <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Journey running to schedule <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Falling or potential falls <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Medication problems or concerns <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hygiene <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please tick which of the following affected how safe or unsafe you felt on arrival, including settling in. Communication from staff <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Staff listening to you <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Waiting times <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Falling or potential falls <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Medication problems or concerns <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hygiene <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																		
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Figure 6.3: Inside of the patient reporting mechanism v1. See Table 6.3 for where each section is reported in the chapter.

Number	Brief Overview	Location of Findings (Page Number)
1	Explanation of what is meant by safety	144
2	Explanation of what is meant by a transfer	144
3	Efficient signposting	144
4	Details for service users to provide further information	145
5	Option for service users to receive feedback (voluntary)	145
6	Individual demographics for research purposes	146
7	Title of the reporting mechanism	146
8	Logo of the reporting mechanism	146
9	Information for service users	147
10	Details of the service user's organisational care transfer	148
11	Reports on how safe or unsafe the service user felt	149
12	Overall rating for the service user's safety	151

Table 6.3: Overview of each segment of the reporting mechanism and location of the findings.

Number 1: Explanation of what is meant by safety

A service user in Group 1 felt that there was a need to identify what a safe journey is for service users.

- “I think that’s what you need on that card on the other side, is identifying what is a safe journey” [EP, Group 1]

An explanation of what is meant by safety within the context of this study was inserted into the reporting mechanism.

Number 2: Explanation of what is meant by transfer

It was felt that service users may consider a transfer to be just the process of moving from one location to another, excluding the preparation that is involved. An explanation of what was meant by a transfer was put into the reporting mechanism to resolve this.

- “I think we need something about the preparation for their journey as well, because otherwise people will just think[...] from their transfer. So we need a little bit of a lead in” [SCHM 2, Group 1]
- “What about on the front if we explain exactly what we mean by a journey?” [JS, Facilitator Group 1]
- “Yeah” [SCHM 2, Group 1]

Although there were concerns about the use of the term journey, such as being interpreted as referring to traffic conditions, it was felt that by defining it on the reporting mechanism this would be resolved.

- “I don’t think you need journey. I think people think journey as, you know like you said, was the traffic...” [EP 1, Group 1]
- “I know, but we’re defining it on the front.” [CCTN, Group 1]
- [...]
- “I think it’s very meaningful, it’s been meaningful from biblical times. You know, people’s journeys. [...] I think it’s very meaningful to most generations, a journey, and it doesn’t just mean transport.” [CCTN, Group 1]

Number 3: Efficient signposting

Signposting was one of the main outcomes of Workshop 1, indicating to service users that by completing the reporting mechanism they were not making a formal complaint. This was again raised in Workshop 2 as being essential in the reporting mechanism.

- “We also need them to understand that it isn’t the complaints route though as well don’t we. We need to be very clear about that.” [CCTN, Group 1]

Related to patient complaints are the outcomes of reporting safety. There were concerns that service users do not comprehend the benefits of reporting, with the worry of blame playing a role in this. Participants in Group 2 were keen for the mechanism to not be a method of blame. This is evident in the reporting mechanism where there is an emphasis on improving services.

- “I think people don’t understand the need to report things, or that there would be any benefit to reporting it.” [ASSA 1, Group 2]
- [...]
- “I think there’s also the fear that if you report it, you’ll get the blame” [SU1, Group 2]

Number 4: Details for service users to provide further information

When pulling the mechanism together, there was only a limited amount of space available. Given that it was important to capture safety during the departure, journey and arrival, there was no available space for service users to expand upon their answers. It was therefore decided that providing them with an option to do this on a separate piece of paper would be a suitable alternative.

Number 5: Option for service users to receive feedback

When participants were discussing the signposting for service users to understand that the reporting mechanism is not a method of complaining, one expert patient stated that the mechanism can be used to **provide feedback** if people have felt unsafe.

- “If it wants to be followed through, the complaints as such could be picked up, and this is the action we took” [EP 2, Group 1]

Within Group 2, having anonymous data was seen to be inadequate as they would not be able to respond to and act upon the individual comments.

- “We couldn’t deal with or manage any issue that are anonymous because we couldn’t address it with the individual, we wouldn’t be able to [tell] if it’s just the one person or if it’s a service-wide problem” [ASSA 2, Group 2]

Although the complaints were acknowledged by the CCTN to be outside of the remit of the tool, the same principle can be applied to any reporting mechanism where feedback should be provided to patients if they want it to be, a process which is supported by the ‘Being

Open' policy (NPSA, 2005) and can mitigate the impact of something going wrong by improving patient-provider relationships (O'Connor, et al., 2010).

Feedback was supported again later in the workshop as an incentive for patients to report their safety.

- “I think also we can promise them that we'll feedback how we have, you know, if we're looking to change” [CCTN, Group 1]
- [...]
- “Otherwise it would be pretty meaningless for them as well, it wouldn't really give them any incentive to, actually write anything down as such” [CCTN, Group 1]

Number 6: Individual demographics for research purposes

For the purpose of developing the reporting mechanism it was necessary to capture some basic demographic information from service users in order to determine which population groups were completing and returning the reporting mechanism. Although this was not raised as a point of inclusion in the workshop, it was felt by the research team that it was necessary in order to determine the demographics of the respondent.

Number 7: Title of the reporting mechanism

The title of the reporting mechanism was chosen based upon two key components of the study; the title of the study (SURE) and the focus on safety.

- “Our folded A4 piece of paper is headed safe and sure, and safe because we want that safety message rather than satisfaction message, and sure being service users reporting experience. So your rainbow can certainly go on the bottom of that.” [AJ, Facilitator Group 2]

Number 8: Logo of the reporting mechanism

The logo was suggested by the PCHM based upon the smiley faces that were incorporated into the reporting mechanism, which received support from other participants within the group. This also helped to fulfil the principle that the reporting mechanism needed to be appealing to service users, which was identified in Workshop 1.

- “I did this earlier; if you had a happy and a smiley face, and connected by a rainbow?” [PCHM, Group 1]
- “Aww. Yeah that's nice” [CCTN, Group 1]
- [...]

- “When people choose postcards, they choose something that they like. It’s fun, and bright.” [CCTN, Group 1]

Number 9: Information for service users

The reporting mechanism is addressed to either the service user or their carer for circumstances when the service user would be unable to complete it themselves.

- “What about where they can’t fill it in for obvious reasons? [...]” [EP2, group 1]
- “That’s where your carer comes in” [EP1, Group 1]
- [...]
- “Yeah could have dear patient or carer on the front” [CCTN, Group 1]

It was felt that due to the number of different forms of receiving patient feedback that currently exist, there needed to be clarity that they are being asked to feedback on their safety, and not any other aspect of their care.

- “I think the clarity of what we’re asking for is vital because we’re looking at such a range of services in different kind of settings; in community care, in the hospitals in the care homes, all over really. And I think the danger is that there’s already a lot of stuff out there, so people become confused about what’s being asked from them. ‘Cause people will automatically think that’s a comment in general terms about whatever service has been provided. I think that’s really vital that it’s clear what we’re asking for” [SCHM 2, group 1]
- “On that postcard we’ll have to explain to them what the purpose of it is” [CCTN, Group 1]
- “Is that capturing their experience, whether they had a good, bad, happy, sad experience. Is that what it... or is it more in terms of patient safety, whether... [SHAR, Group 1]
- “It’s got to be around safety” [JS, Facilitator Group 1]
- “It’s got to be around safety” [CCTN, Group 1]
- “Yeah, so that’s what we need to encapsulate[...] so we have to have that emphasis on safety, won’t we?” [SHAR, Group 1]

Number 10: Details of the service user's organisational care transfer

Departure, Journey and Arrival

The organisational care transfer was divided into three separate stages; the departure, the journey and the arrival. It was thought that having more specific information on the different stages of the organisational care transfer would allow the reports to be utilised better to improve services. The healthcare professional would be able to explore at which points of the transfer the service user had felt safe or unsafe and address those individually.

- “we thought that most journeys, and I like your idea of defining a journey and what service user safety is, have a beginning, and a middle and an end. So, we would like to start with this panel, which is... we've got a day and a date... place of departure, so where did you depart from?” [AJ, Facilitator Group 2]
- “at which point did we see a smiley face, and at which point was it a negative one, and why. And then, and just... if there's an improvement that's needed somewhere, is the waiting time too long...” [PCHM, Group 1]

These three stages were originally labelled 'discharge', 'transfer' and 'admission'. This was changed prior to the piloting based upon feedback from the CCTN from Group 1 post-workshop as it was felt that they did not accurately capture each of the different types of care transfer. For example people leaving from or going home would not be classed as being discharged from home or admitted to home. 'Transfer' was changed as it was thought it may confuse service users as the whole process, including departure and arrival is inclusive of the term 'transfer'. During Workshop 2, the use of the term transfer was also thought to be ambiguous and open to misinterpretation by service users.

- “I'm never happy with transfer because people... some people, particularly the public, would automatically think you're talking about wheels, as opposed to the journey” [CCTN, Group 1]

Collecting Transfer Information

The date and location of the transfer were left open so that service users could complete these themselves. It was important to capture the departure and arrival points along with the mode of transport so that the reporting mechanism could be generic and used across many different services. This was deemed a necessary feature of a patient reporting mechanism for organisational care transfers during Workshop 1, and would provide enough information for the relevant services to be able to learn from the service user reports. However concerns

were raised in Workshop 2 as to the appropriateness of having a generic reporting mechanism, and that there may need to be a range of reporting mechanisms.

- “This is a very difficult task because there’s so many different areas, so many different departments. To get one tool that would work for everyone is almost... I would imagine quite [difficult]” [ASSA 1, Group 2]
- “We really were then hooked on the fact that we probably needed a range of tools, that one-size-fits-all didn’t work, that there were generational mechanisms that would work better with younger people than older people.” [AJ, Facilitator Group 2]

Number 11: Reports on how safe or unsafe the service user felt

Question Selection

Questions were designed to direct the service user into focusing specifically on safety issues that had arisen during Phase 1 of the study.

- “And then we had the box in the middle with a series of questions based on Jason’s initial themes” [AJ, Facilitator Group 2]

It was felt that patients would have to be given this direction, rather than open-ended questions such as ‘What made you feel safe during your journey?’, so that they did not focus on issues irrelevant to their healthcare.

- “Did you think that your journey between such and such and such and such was safe? Because that’s how describe the journey anyway. Which therefore would hopefully mean something...” [CCTN, Group 1]
- “I think the danger with that feedback, they’re thinking what the traffic was like” [SCHM 2, Group 1]

Standardised Reporting

Group 1 suggested a way of standardising the reporting mechanism across organisations, which would alleviate the concerns held in Group 2 that a reporting mechanism could not be standardised. By using the patient perceptions of safety identified in Phase 1 as the basis for the reporting mechanism, it is going some way to making it a standardised system. Only if perceptions changed based upon the type of care transfer would there need to be a non-standardised reporting mechanism.

- “So the issues that you were bringing up, about communication and trust, so if we kind of capture that and standardise that somehow on the back, about the

information you were given. Because that's all that builds in to the safety aspects of that journey through your... through the particular care issue." [CCTN, Group 1]

Smiley Faces

When discussing the possible use of postcards, it was suggested that they were a good idea as they could be distributed at any point throughout the organisational care transfer. They were also supported for their simplicity, and the use of smiley faces was something that built upon the notion of simplicity and continued throughout the session. They were also incorporated into the logo of the reporting mechanism.

- "You could have little postcards everywhere, every part of the journey" [SCHM 2, Group 1]
- [...]
- "One side with a smiley face and one side with a... [unhappy face]. And then straight away you can see" [PCHM, Group 1]
- "Something simple. I think the most simple ideas are the most effective" [SHAR, Group 1]

The traffic light system was suggested by the facilitator in Group 2 when discussing the use of stickers for service users to report their safety, although it was suggested that for complicated issues the traffic light system would not be comprehensive enough.

- "we could have traffic lights; red, orange and green. And so that bit in the ward was really green, but actually the ambulance car, the person wasn't very friendly and didn't help me and so that is red." [AJ, Facilitator Group 2]
- [...]
- "as you were saying where you should have a red, a green, amber, and identifying how happy you were, but the detail this lady's describing would need to be addressed quite intricately" [ASSA 2, Group 2]
- "If we don't have enough detail in this reporting tool, then acting on it and feeding back is lost to the system." [AJ, Facilitator Group 2]

Despite these points being raised, it was never stipulated the amount of detail that was necessary in order to learn from patient reports, and so it was decided that as a starting point the traffic light system of smiley faces would suffice. This could be later modified based upon feedback during the piloting stages.

Positive and Negative Experiences

Although the capturing of positive and negative experiences of safety was part of the original objective for the reporting mechanism based upon the AI methodology, this received support from participants.

- “you’ve got to look at both sides. And that’s how we worked in industry; we looked at... you just didn’t concentrate on the bad, you concentrated on the good as well. Because people... it’s a good morale booster and it’s also a good working practice to get them to go on that pathway” [EP 1, Group 1]
- “It would be good feedback for people that were doing it well” [NUSU 3, Group 2]

Number 12: Overall rating for the service user’s safety

An overall rating for the service user’s safety was introduced so as to capture how the individual components of safety, captured in ‘Number 11’, fit into their overall perspective of safety. For example exploring how each individual component of safety impacts upon on their overall feeling.

6.3.2 Reflections of Workshop 2

6.3.2.1 Emphasis on Group 1 Data

It may appear that the reporting mechanism was designed primarily on the data collected on Group 1. However this was not the case, and the emphasis placed upon Group 1 recordings is an artefact of the voice recorder not capturing the discussions in Group 2 during the convergent thinking session. Group 2 had an equal input into the design of the reporting mechanism during the final ‘sharing of ideas’ section of the workshop. This is best evidenced in the use of a system that was not a postcard, which was the suggested reporting mechanism of Group 1.

6.3.2.2 Thinking Differently

One participant queried the use of the Thinking Differently methods, interpreting the use of them as an implication that their current modus operandi is wrong.

- “Why do we have to think so differently? What is it that we’ve done so terribly wrong that makes us feel like we have to think differently?” [CCTN, Group 1]

The same participant questioned the extent to which people are able to think differently.

- “I’d like to leap out of the box, but how far can you leap out of the box to create this mechanism? I don’t know.” [CCTN, Group 1]

Despite these initial reservations, the CCTN and all other participants were actively involved in the discussions arising from the Thinking Differently methods. This also provided an interesting reflection point as participants can only hold a finite amount of knowledge, and so therefore moving from one schema to another is still operating within their own knowledge constructs. This limits the extent to which participants can think outside of the box. However the use of collaborative groups of participants with different backgrounds allows them to increase their knowledge by taking into account others' perspectives, supporting the rationale for using collaborative workshops as the means of developing the reporting mechanism.

6.3.2.3 Patient Advocates

Participants spoke about the ability for advocates to report the patient's perspective on safety. For example for those that are physically unable to complete the reporting mechanism, it was thought that advocates via special training would be able to complete it with the patient's input.

- “when you're talking about the people who... wouldn't be able to communicate [their safety], you know, how are we going to capture that? [PCHM, Group 1]
- “You can do it with a little bit of staff training. If you have an escort going with them from the care home, you can do a little bit of training about this is how we're going to capture the information with these emotion cards in that case if somebody has communication difficulties, and then you can do that journey with them.” [SCHM 1, Group 1]

The overall responsibility for this lies with the individual organisations during the piloting of the reporting mechanism. It was identified that this approach does not always work, with some patients travelling without an advocate.

- “If it was an acute admission and then, from our setting then they would have an escort. Whereas if it was from a transfer from hospital back they wouldn't, so you would lose that.” [PCHM, Group 1]

6.3.2.4 Learning from the Service User Reports

It was identified that the service user reports of their safety could be useful in the changing of the systems that had made them feel unsafe.

- “I think it would be great if people could be fed back their information as well [...] and then it makes you want to improve it” [NUSU 3, Group 2]

However there were concerns that this would not apply to every part of the transfer as the responsibility for other systems lies with other organisations.

- “we want instant feedback to change our systems” [SCHM 1, Group 1]
- “And so we can change the system within our environment but we can’t change the system anywhere else” [PCHM, Group 1]
- “Absolutely, yeah” [SCHM 1, Group 1]
- “that person[...] needs to be assured. Basically something’s going to happen, there is going to be a change[...]” [PCHM, Group 1]
- “But locally, we can change it... I mean that’s the thing, it’s probably not very good for research purposes, but what we’d be looking to do, if we could capture someone’s experience like that we could change it very quickly” [SCHM 1, Group 1]
- “What’s going to happen to that information, by whom and by when?” [EP 2, Group 1]
- “And where it goes to” [PCHM, Group 1]

A solution to this that was proposed was using the feedback from patients to approach the relevant organisation, although this would require further work before being an applicable solution.

- “You might... relating to ambulance services, with the information you’ve got you could turn around to the [organisation name removed] ambulance station, ‘look, patients are getting good treatment while using the service, but accessing the service, they’re not’” [EP 1, Group 1]

6.3.2.5 Individual Agendas

In comparison to Workshop 1 participants appeared to bring with them fewer individual agendas, or if they were present, they were hidden by the structure of the workshop. All participants appeared to have an input into both the divergent and convergent thinking break-off sessions. It is possible that this is an outcome of the recruitment strategy in that many of the participants had already participated in Workshop 1, and therefore had already had the opportunity to express their personal stories or felt that their organisations were not threatened by the process of developing the reporting mechanism.

6.4 Chapter Summary

The two workshops discussed in this chapter formed the Plan (Design) stage of the first cycle of developing and piloting a reporting mechanism that would allow service users to identify and to report their safety when going through an organisational care transfer. This built upon the findings from Phase 1 (Chapter 5), where service users defined what safety meant to them within an organisational care transfer context. Subsequently, the mechanism allowed service users to report this self-definition of safety rather than one based upon healthcare professional perspectives

Participants in Workshop 1 identified a number of different possible mechanisms for service users to report on their safety. Out of those identified, participants felt that a questionnaire and / or a leaflet were the most appropriate method of capturing these patient reports of safety. Key principles that were fundamental to the reporting mechanism were also identified, including that it needed to be patient-centred, short and concise with clear signposting and optionally anonymous. A further key principle was that it needed to focus on safe as well as unsafe care to provide a balanced viewpoint and to avoid any confusion with complaints mechanisms. This relates closely to the AI methodology that forms part of the AR cycle, where a focus on positives is thought to drive future improvement (Reed, 2007).

Discussions were also held around how the reporting mechanism would fit with current systems. It was identified that within the organisations involved in this study or known to participants outside of their organisations, there was no mechanism in existence for service users to report their safety on both admission and discharge from services. Concerns were raised regarding the roll-out of the reporting mechanism, such as what would drive organisations to implement and learn from the patient reports, as well as who responsibility would lie with to monitor and act upon the reports. These implications are considered in further detail in the Discussion chapter.

In addition to the direct findings from Workshop 1, reflections by the researcher and observers also provided a valuable insight into the data collection process. Firstly was that during the workshop there had been no attempt to develop a reporting mechanism. Secondly was that participants focused on the reporting of patient satisfaction as opposed to patient safety. It is thought that these were the result of a lack of direction given to participants regarding what was expected of them and what was not expected of a reporting mechanism. Each of these was addressed in Workshop 2.

Following Workshop 2, the participants had developed a tangible reporting mechanism through the process of divergent and convergent thinking congruent with Thinking Differently methodology. It was based upon the key principles that had been identified in Workshop 1 and the service user definitions of safety identified in Phase 1. Again concerns were raised about how organisations would learn from the service user reports, which is discussed in greater detail in Chapter 8.

The following chapter will explain how the reporting mechanism was piloted and further refined through the rest of the two AR cycles explained in Chapter 3.

Chapter 7: Piloting of the Reporting Mechanism

7.1 Chapter Overview

The previous two chapters have detailed how the service user definitions of safety were developed (Chapter 5), and how the reporting mechanism was developed (Chapter 6), linking in the service user definitions of safety. The latter of these chapters formed the Plan (Design) stage of the first AR (AI) cycle. This chapter provides the findings from the remaining first cycle; Action (Deliver), Observe and Reflect, and the full second cycle.

More specifically, the Action (Deliver) stages of the cycles explore how the reporting mechanism was distributed to organisations and subsequently to service users. The Observe stages explore the service user reports of safety, reporting on how many reports of safe and unsafe care are provided by service users in the different domains of safety that were identified in Phase 1 and included in the reporting mechanism. The Reflect stage of the cycle represents the feedback provided by service users, either in the form of the evaluation form or interviews. This feedback informed the redevelopment of the reporting mechanism at the end of the first cycle, and was used in the formation of the recommendations for future piloting and roll-out of the reporting mechanism at the end of Cycle 2.

7.2 Cycle 1

7.2.1 Delivery (Action) of the Mechanism

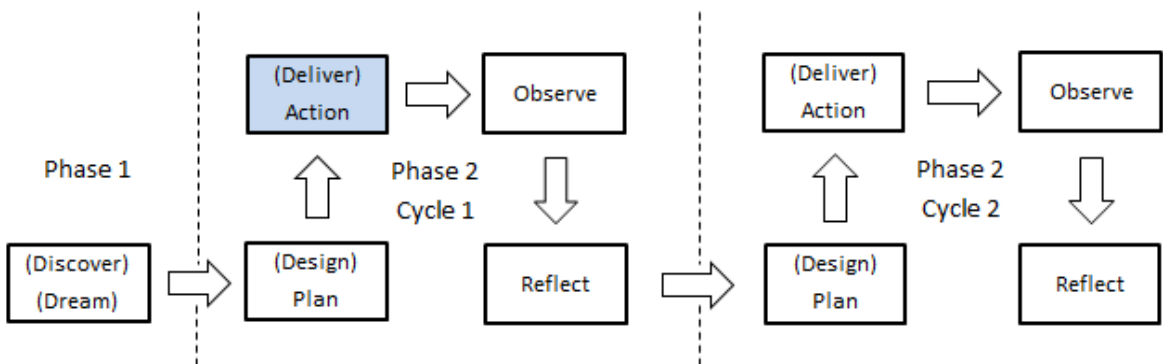


Figure 7.1: Where the (Deliver) Action stage of piloting fits into the methodological cycles (Phase 2 Cycle 1).

Out of the 120 reporting mechanisms distributed to the six organisations, 91 were distributed to service users. The three NHS community care teams distributed all 60 of their reporting

mechanisms, the two social care homes distributed 25 and the private nursing home distributed six. A full summary of distribution and response rates is provided in Table 7.1.

Organisation	Number Distributed	Response Rate
<i>NHS Community Care Team 1</i>	20 / 20 (100%)	5 / 20 (25%)
<i>NHS Community Care Team 2</i>	20 / 20 (100%)	4 / 20 (20%)
<i>NHS Community Care Team 3</i>	20 / 20 (100%)	10 / 20 (50%)
<i>Social Care Home 1</i>	12 / 20 (60%)	8 / 12 (67%)
<i>Social Care Home 2</i>	13 / 20 (65%)	8 / 13 (62%)
<i>Private Nursing Home</i>	6 / 20 (30%)	6 / 6 (100%)
Total	91 / 120 (76%)	41 / 91 (45%)

Table 7.1: Distribution rate from organisations to service users and response rates (Phase 2 Cycle 1).

The Private Nursing Home reported a lower distribution rate due to a limited number of organisational care transfers into and out of the organisation as well as specifically targeting service users who had stated they would be willing to participate.

From the 91 reporting mechanism distributed, 56 were given to patients and two were given to family members or carers, both of which by Social Care Home 1. Data for the other 33 reporting mechanisms was unavailable. Where data was available the average age of service users was 79 years, 23 service users were male and 40 were female. All were White British. Although data was collected on medical conditions, this was not extensive enough to be used in an exploration of the findings. Twenty seven were given to service users on arrival to the service, whilst 16 were given on departure. These are broken down by organisation in Table 7.2.

Organisation	Distribution				
	Average Age	Male	Female	Arrival	Departure
NHS Community Care Team 1	79	12	8	3*	0*
NHS Community Care Team 2	0*	0*	0*	0*	0*
NHS Community Care Team 3	78	3	17	10	10
Social Care Home 1	79*	5*	5*	7*	0*
Social Care Home 2	81	3	10	7	6
Private Nursing Home	0*	0*	0*	0*	0*
Total	79	23	40	27	16

*Denotes that some or all data is missing

N.B. Average age is rounded to 1 decimal place. Where the value is 0, it was not included in the Total calculation

Table 7.2: Description of who the reporting mechanism was distributed to by organisation (Phase 2 Cycle 1).

In total 41 (45%) people responded to the reporting mechanism. Where data was available the average age of service users that responded was 79 years, 11 service users were male and 17 were female. Fifteen respondents were given the reporting mechanism on arrival into the service, whilst seven were given on departure. These are broken down by organisation in Table 7.3.

Organisation	Respondents					
	Number of Respondents	Average Age	Male	Female	Arrival	Departure
NHS Community Care Team 1	5	77	3	2	0*	0*
NHS Community Care Team 2	4	0*	0*	0*	0*	0*
NHS Community Care Team 3	10	78	2	8	4	6
Social Care Home 1	8	75*	3*	2*	4*	0*
Social Care Home 2	8	81	3	5	7	1
Private Nursing Home	6	0*	0*	0*	0*	0*
Total	41	78	11	17	15	7

*Denotes that some or all data is missing

N.B. Average age is rounded to 1 decimal place. Where the value is 0, it was not included in the Total calculation

Table 7.3: Description of who responded to the reporting mechanism by organisation (Phase 2 Cycle 1).

Where data is available, the ratios of respondents have been developed as a form of comparison between the respondents and the overall sampled population that the reporting mechanism was distributed to. The ratio of females to males that responded to the reporting mechanism (1.55) remained similar to the ratio that it was distributed to (1.74). However there was a large difference between the ratio of arrival to departure that responded (2.14) compared with the ratio that it was distributed to (1.69). The average age of both the sampled population and respondents remained similar, only changing from 79 to 78.

This suggests that gender and age of participants had no influence on responding to the reporting mechanism. The increase in response to the reporting mechanism when given to service users on arrival to the service can be attributed to one of two factors, both of which are related to the service users' ongoing care. The first of these is that service users would have been able to receive more assistance in completing the reporting mechanism; whether in relation to answering the questions or by being able to give the reporting mechanism directly back to their healthcare professional rather than having to post it themselves. The second of these is that participants may have felt obligated to complete the reporting mechanism so that it did not have an impact upon their care.

7.2.2 Observation

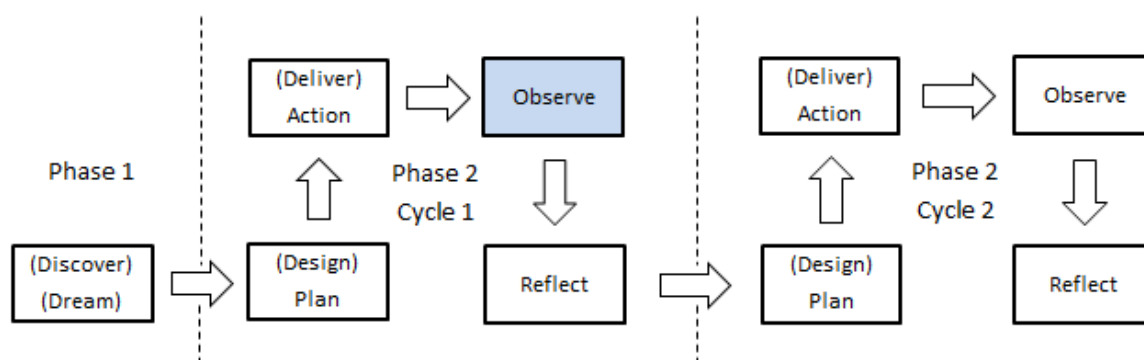


Figure 7.2: Where the Observation stage of piloting fits into the methodological cycles (Phase 2 Cycle 1).

When completing the reporting mechanism, service users were asked the location of their departure and arrival points (Hospital, Home, Nursing or Residential Home, Community Care or Other) as well as their mode of transport (Ambulance, Private Car, Taxi, Patient Transport or Other). A summary of each of these is provided in Table 7.4.

Departure					
<i>Hospital</i>	<i>Home</i>	<i>Nursing or Residential Home</i>	<i>Community Care</i>	<i>Other</i>	<i>Unstated</i>
17	13	4	2	1*	4

Journey					
<i>Ambulance</i>	<i>Private Car</i>	<i>Taxi</i>	<i>Patient Transport</i>	<i>Other</i>	<i>Unstated</i>
22***	6	5***	3	1**	4

Arrival					
<i>Hospital</i>	<i>Home</i>	<i>Nursing or Residential Home</i>	<i>Community Care</i>	<i>Other</i>	<i>Unstated</i>
10	7	8	5	4****	6

*Participant did not expand

**Walking

***One participant selected both Ambulance and Taxi.

****Social Care Home

Table 7.4: Self-reported locations and journey types by respondents (Phase 2 Cycle 1).

Service users reported their safety across a number of domains, each of which was based on the findings from Phase 1. The following section details how safe the respondents felt during their departure (Table 7.5), journey (Table 7.6) and arrival (Table 7.7). Where the totals do not equate to 41, there was missing data. In total, there were 40 reports of respondents feeling unsafe. Out the 41 organisational care transfers that were reported on by service users, 13 (31.7%) discrete respondents reported feeling unsafe in at least one domain. As AI informed the development of the reporting mechanism and was used to underpin the study, it was important to measure both safe and unsafe care. Therefore equal weighting has been provided to the reports of feeling safe as those of feeling unsafe. Where service users have reported feeling unsafe, it has been classed as a patient safety incident. However reports of feeling unsafe by the same service user across more than one domain of safety do not constitute more than one incident. There is an emphasis placed upon unsafe rather than safe care here so as to create a comparison with current literature on service user reporting of safety, which has focused solely upon reports of unsafe care (King, et al., 2010).

Departure

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
27	8	1	30	6	1	17	12	6	17	12	2

Medication			Hygiene			Other			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
14	10	5	24	9	1	1	2	1	18	1	1

Table 7.5: Service user reports of safety during their departure (Phase 2 Cycle 1).

During their departure from services, respondents reported feeling safe a total of 130 times across the seven domains and unsafe a total of 17 times, with some respondents reporting feeling unsafe across more than one domain. The majority of reports recorded service users feeling either safe or neutral. Nine discrete respondents reported feeling unsafe in at least one domain during their departure, giving an incident rate of 21.95% for the point of departure. Although only one respondent reported feeling unsafe overall, this was a result of those service users reporting feeling unsafe not answering the question. Out of the nine, one reported feeling unsafe, one reported neutral or not applicable and six left the question blank. Only one service user who had reported feeling unsafe in one or more domains then proceeded to report feeling safe overall.

The respondent that had rated 'other' as unsafe expanded on their answer, stating that 'I did not know why I was delayed leaving hospital' [029, Reporting Mechanism]. This does not represent a potentially new domain of safety as it would perhaps have been more appropriate in the 'communication from staff'. The other service users that reported 'other' did not expand on their answers and so no further information can be retrieved from these.

Journey

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
24	9	0	27	6	0	22	7	4	19	12	1

Medication			Hygiene			Other			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
17	12	1	21	12	0	0	1	1	18	3	0

Table 7.6: Service user reports of safety during their journey (Phase 2 Cycle 1).

During the journey stage of the transfer there were 130 reports of feeling safe across the seven domains, whilst they felt unsafe a total of seven times across the seven domains, with some respondents reporting feeling unsafe across more than one. The majority of respondents felt either safe or were neutral. Five discrete respondents reported feeling unsafe in at least one domain during their journey, giving an incident rate of 12.2% during the journey. No respondents reported feeling unsafe overall. Two of the five respondents that had reported feeling unsafe in at least one domain did not answer this question; two reported feeling safe overall and one reported being neutral or not applicable.

One respondent rated 'other' safety as neutral, however they did not expand on their answer. Two service users expanded on their answer without giving a rating to their safety. The first of these was 'Had pain' [090, Reporting Mechanism]. The second was 'Ambulances come too early. Taxi yes (journey running to schedule). Medication N/A' [125, Reporting Mechanism], which related to the items that were left blank. This data could not be easily translated into the blank reports and so was not included in the total values reported in Table 7.6.

Arrival

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
28	4	2	27	7	1	21	9	4	21	10	2

Medication			Hygiene			Other			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
23	9	3	24	8	1	3	1	3	20	0	2

Table 7.7: Service user reports of safety during their arrival (Phase 2 Cycle 1).

During their arrival, there were 147 reports of feeling safe across the seven domains, whilst there were 16 reports of feeling unsafe across the seven domains, with some respondents reporting feeling unsafe across more than one. The majority of respondents felt either safe or were neutral. Six discrete respondents reported feeling unsafe in at least one domain during their arrival, giving an incident rate of 14.63%. Three that had reported feeling unsafe in one or more domains did not answer the overall question, two reported feeling unsafe overall and one reported feeling safe.

Seven respondents gave a rating for 'other' safety issues. Three of these reported feeling safe, one reported neutral or not applicable and three reported feeling unsafe. Those that reported feeling safe expanded on their answers with 'Staff had arranged for me to be in room next to my wife which made me feel champion. It was heaven' [029, Reporting Mechanism] and 'Felt very safe and comfortable' [033, Reporting Mechanism]. The third respondent did not expand on their answer. The service user that reported neutral also did not expand on their answer. Those that gave a rating of unsafe expanded on their answers with 'Waiting times too long' [125, Reporting Mechanism], 'Too tired and cold' [087, Reporting Mechanism] and 'Resident confused in A&E' [090, Reporting Mechanism]. The latter of these was completed by an advocate that had gone with the service user during the organisational care transfer and completed the mechanism with their assistance.

One respondent rated 'other' safety as neutral, however they did not expand on their answer. Two service users expanded on their answer without giving a rating to their safety. The first of these was 'Had pain' [090, Reporting Mechanism]. The second was 'Ambulances come too early. Taxi yes (journey running to schedule). Medication N/A' [125, Reporting Mechanism], which related to the items that were left blank. This data could not be easily

translated into the blank reports and so was not included in the total values reported in Table 7.7.

Despite having data to suggest that targeting service users entering the service would have increased the response rates, this was not the objective of this study. The objective was to develop the reporting mechanism, and so any changes to the sampling strategy would have impacted upon any comparisons that could have been made between Cycle 1 and Cycle 2 of the piloting; i.e. it would not have been possible to determine if the changes to the reporting mechanism had impacted upon the saliency of service users.

7.2.3 Reflection

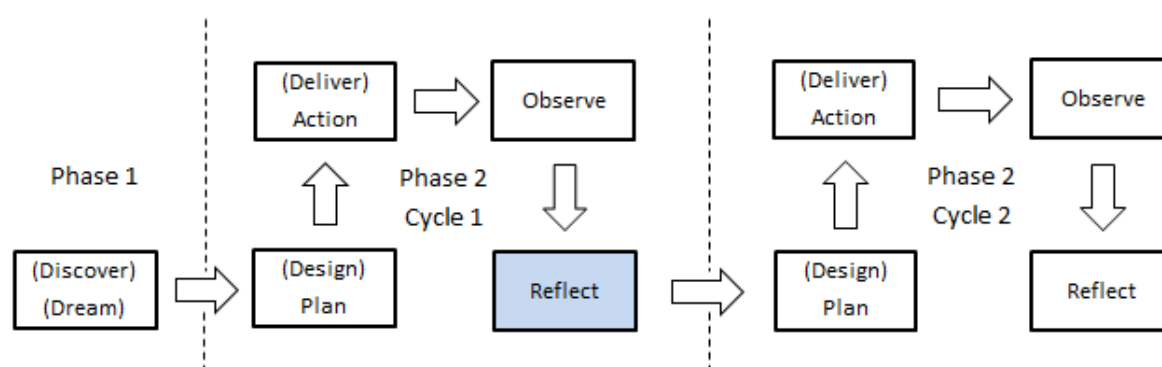


Figure 7.3: Where the Reflection stage of piloting fits into the methodological cycles (Phase 2 Cycle 1).

Evaluation data on Cycle 1 of piloting was collected through evaluation forms and two interviews with service users (Pil01 and Pil02a). Pil02a's carer also participated in the interview (Pil02b). This data is presented in terms of the seven items on the evaluation form. Not all respondents returned the evaluation form with the reporting mechanism, whilst out of those that did, some did not complete every question. Caution was taken when considering the responses as there is potential for self-selecting bias. It was possible that those that were happy with the reporting mechanism completed the evaluation form, whilst those unhappy with the reporting mechanism did not complete and return it.

Where changes were made to the reporting mechanism for Cycle 2 of piloting, these are detailed in the Design (Plan) stage of that research cycle (Page 171). The rest of the feedback is reflected upon within this section.

Item Number	Item	Agreed	Neither Agreed or Disagreed	Disagreed
1	<i>I understood the purpose of the Patient Safety Survey</i>	23	6	0
2	<i>I understood what was meant by 'your transfer'</i>	21	5	2
3	<i>I understood each of the questions</i>	24	4	0
4	<i>The questions were appropriate</i>	23	4	0
5	<i>There was nothing missing from the Patient Safety Survey</i>	20	6	2
6	<i>I had no concerns about completing the Patient Safety Survey</i>	28	0	1
7	<i>I feel the Patient Safety Survey allows me to provide useful feedback about the healthcare I have received</i>	25	4	0

Table 7.8: Answers to the seven items on the evaluation form (Phase 2 Cycle 1).

Item 1: 'I understood the purpose of the Patient Safety Survey'

Out of 32 respondents, 23 agreed with the statement, six neither agreed nor disagreed and three did not select an answer. No participants disagreed. This suggests that the respondents were in general satisfied that the purpose of the reporting mechanism was appropriately incorporated into the reporting mechanism. Based upon this evaluation data and the good response rate from service users it was felt that the general design of the reporting mechanism was successful in that it achieved a good degree of saliency amongst participants, with only minor amendments needed.

Item 2: 'I understood what was meant by 'your transfer''

From 32 respondents, 21 agreed with the statement, five neither agreed nor disagreed and four did not select an answer. Two participants disagreed. One participant that disagreed expanded upon their answer by stating:

- 'It was not clear whether you meant transfer from home to hospital (admission) or transfer from hospital to community care home' [004, Evaluation Form]

One interview participant (Pil01) also struggled with what was meant by 'your transfer', particularly location, departure / journey and what was entailed with each one. Despite this, interview data from Pil02a and Pil02b suggests that the term 'your transfer' is clear.

- "So for example, the departure, journey and arrival, did they all make sense when you were filling it out?" [JS, Interviewer]
- "From one... departure you mean from one association to another?" [Pil02b]

- “Yeah.” [JS, Interviewer]
- “Yeah, yeah we do because the hospital transferred you and we understand it was a transfer from the hospital caring into this caring, yeah?” [Pil02b]
- “Oh yeah, yeah.” [Pil02a]

Although two participants did not understand what was meant by ‘your transfer’, no changes were made to the reporting mechanism based upon this feedback. For the majority of respondents the term and its definition were clear. Without receiving detailed feedback from service users on how the term could be made clearer it was not possible to make any changes.

Item 3: ‘I understood each of the questions’

24 respondents agreed with this statement, 4 neither agreed nor disagreed, nobody disagreed and 4 did not select an answer. There was no interview data to support these findings. The wording of the questions remained the same within the reporting mechanism for Cycle 2 of piloting.

Item 4: ‘The questions were appropriate’

Out of the 32 respondents, 23 agreed with this statement, 4 neither agreed nor disagreed, none disagreed and 5 did not select an answer. This was supported by the interview with Pil02a and Pil02b, who found the questions appropriate, although they felt that there needed to be a clear option for ‘not applicable’. Participants were expected to tick the middle box if the answer was not applicable, but the number of people who missed sections out make it appear that they were doing so as they were not applicable, as explained below in an interview.

- “Medication problems or concerns, well there’s no tick on any of them there. So medication problems and concerns” [Pil02b]
- “We didn’t have any” [Pil02a]
- [...]
- “Can I just ask the ones where you haven’t ticked, for example [the journey section], was that because you didn’t feel like they didn’t apply to you?” [JS, Interviewer]
- “Because it was a private car” [Pil02b]

This was further clarified later in the interview.

- “he’s left it blank because it wasn’t applicable so how do you feel about that Alan, because you obviously understood that you didn’t have to reply to it” [Pil02b]

- “Well I must have done at the time but now I don’t remember you know. But I suppose you’re right, possibly put a not applicable option in, yeah.” [Pil02a]

Furthermore, questions posed about the date and location were deemed to be unnecessary, which is apparent from the number of respondents that did not complete them (departure date n=22, departure location n=25, journey date n=23, journey location n=33, arrival date n=23, arrival location n=27). Interview data from Pil02b further supports this, displaying confusion at the need for the information.

- “Well we’re not answering it are we, you’re not asking us to fill it in so why is it on there?” [Pil02b]

Interpreting the reports of safety also suggests that the overall section is often not completed (departure n=21, journey n=20, arrival n=19), perhaps as a result of people not associating it with the main questions or not seeing it as important. Changes were made to the reporting mechanism for Cycle 2 of piloting based upon this feedback, which are recorded on pages 171-175.

Item 5: ‘There was nothing missing from the Patient Safety Survey’

20 respondents agreed that there wasn’t anything missing, 6 neither agreed nor disagreed, 2 disagreed and 4 did not answer the question. It was unclear what one of the respondents that had disagreed was trying to disclose.

- ‘On another occasion I had to wait 13 hours to be transferred from hospital to home and arrived at 2.50am’ [033, Evaluation Form]

It is possible that they felt the form did not capture the length of waiting times for the transfer or the time that they arrived home was inappropriate. Without further information or being able to speak with the service user it was not possible to explore this further.

The need for service users to expand upon their answers became apparent shortly after piloting began. A number of instances of people feeling unsafe were reported (discharge n=17, journey n=7, admission n=16), however it was not possible to determine exactly why they felt unsafe.

During an interview with a respondent, she recommended some changes in order for her to be able to complete the form.

- ‘The participant stated that she found it difficult to complete the form as she couldn’t express what had happened, i.e. give a detailed explanation of events.’ [JS interview notes, Pil01 interview]
- ‘A section was suggested for when in hospital as well as the transfer’ [JS interview notes, Pil01 interview]

During a different interview, the Pil02b stated that having any more sections would make the form confusing for people to complete.

- “It’s going to make your leaflet frightening for people to take too much in” [Pil02b]

Interview data from Pil02b suggests that there weren’t any questions missing, explaining that because they hadn’t filled out the ‘other’ section it meant they couldn’t think of anything that may be missing.

- “you’ve covered everything on there and we haven’t thought of anything that you haven’t covered” [Pil02b]

The changes made to the reporting mechanism based upon this feedback are detailed on pages 171-175.

Item 6: ‘I had no concerns about completing the Patient Safety Survey’

28 agreed that they had no problems, none neither agreed nor disagreed, 1 disagreed and 3 didn’t select an answer. The person that disagreed found the colour system confusing.

- ‘Being visually impaired I found the form difficult to complete. The colour system was confusing’ [105, Evaluation Form]

This was an interesting response as the colour system has previously been identified as being a particular strength of the reporting tool, as outlined by Pil02b who stated that she has experience of caring with a relative who has very poor eyesight.

- “I think this is very easy to follow, your colour co-ordination of it. That makes it easy for people with bad eye-sight, so I think it’s a good leaflet.” [Pil02b]

Size of the text was also highlighted in an interview with a service user.

- “If it’s all that size [pointing to the main title] it’d be better for me because my eyesight is very poor” [Pil02a]

- “anything that is controversial, [Pil02a] would get me to read it through and sight it first anyway, so the print on there wouldn’t really matter. It would matter if he was on his own.” [Pil02b]

Coupled with the text was the size of the tick-boxes, which were recommended to be increased in size for people with poor vision.

- “For not very well sighted persons, could your tick boxes be a bit bigger do you think?” [Pil02b]
- “Aha.” [Pil02a]
- “make your tick boxes a bit bigger I’d say, remove [the date and location parts] and take your tick boxes just a bit bigger because you’ll have a bit more room” [Pil02b]

Continuing the theme of making the reporting tool suitable for service users with poor eyesight, the participants stated that the lines in between each question help to guide the respondent.

- “I think the lines are helpful” [Pil02b]
- “I think the lines *are* helpful” [Pil02a]
- “Because you get one, you know you’ve got quite a bit to fit in, and one, if you didn’t have the lines could grow into the other when the person is not really good sighted.” [Pil02b]

To make the form clearer it was also recommended that the main section of the form, the reporting of how safe the person felt, should take up the most amount of space.

- “And you’ve got quite a lot of space allocated there and you perhaps don’t need it as much there [the leaving point / transport type / arriving point], it might be here [the central part] where you need to space it out more.” [Pil02b]
- “Where the most important part is?” [JS, Interviewer]
- “Yeah.” [Pil02b]

Another written comment stated (despite agreeing that there were no concerns):

- ‘I could not write because of difficulties with my hands and needed staff to help’ [029, Evaluation Form]

This is an artefact of using a paper-based reporting mechanism. However at this point in time there was no alternative, and so it is promising that the service user was able to ask for help in completing the mechanism and evaluation form.

Changes were made to the reporting mechanism for Cycle 2 of piloting based upon this feedback, which are recorded on pages 171-175.

Item 7: 'I feel the Patient Safety Survey allows me to provide useful feedback about the healthcare I have received'

25 respondents agreed with this statement, 4 neither agreed nor disagreed and 3 didn't select an answer. No respondents disagreed. During an interview with a respondent and their carer they stated that if they were asked to, they would complete the reporting tool again in the future.

- “Yeah I don't see why not” [Pil02a]
- “Well yeah because it's easy to understand. I think with the changes you've said it's quite easy to understand, yes.” [Pil02b]

The responses to this question suggest that there was a high degree of saliency amongst respondents as they were able to perceive the benefits of completing a reporting mechanism on their safety when going through an organisational care transfer.

7.2.4 Summary of Cycle 1

There was a high distribution rate amongst the different organisations. The full quotas (100%) of reporting mechanisms were distributed by the NHS community care teams over the period of piloting. The social care homes did not distribute their full quota for reasons unknown, with 62.5% of their reporting mechanisms distributed to service users. The private nursing home distributed far fewer (30%), although this was due to having fewer organisational care transfers of service users that would have been eligible to participate. This was further exacerbated by the private nursing home specifically targeting service users willing to respond, which reduced the potential number of service users they were able to distribute to.

Out of the reporting mechanisms that were distributed, responses were of an acceptable level. Those in NHS community care teams were less likely to respond than those in social care homes, perhaps indicative of the nature of care that those in the social care homes were receiving; they were more reliant on their healthcare professionals than those in the community, and were perhaps more inclined to complete the reporting mechanism. There were no large differences in the age or gender balance of respondents in comparison to the target population. However responses were higher when the reporting mechanism was

distributed to service users on arrival into the service in comparison to being distributed on departure. Again this is perhaps reflective of service users being dependent upon their healthcare professionals and therefore felt more inclined to complete the reporting mechanism. An alternative explanation is that the healthcare professionals were able to remind service users to complete it.

From the actual reports on safety, it was evident that service users were able to identify and report how safe they felt during their organisational care transfer. These reports of safety varied depending upon the stage of the transfer; the discharge gave the most amounts of reports of feeling unsafe, followed by the admission and finally the journey itself. This is indicative of the nature of healthcare, where transitions and handovers across organisational boundaries are amongst the most risky. That the journey itself resulted in the fewest reports further signifies this, as at this point of the transfer the service user is under the care of one team of healthcare professionals; it is representative of one episode of healthcare.

Finally, evaluation feedback from service users was largely positive in both the interviews and returned evaluation forms. Small changes to the reporting mechanism were recommended, although some of these were unable to be implemented due to cost restraints (such as catering for sight difficulties). An overview of the changes that were made to the reporting mechanism based upon this feedback is provided in 7.3.1; the Design (Plan) of Cycle 2 of the AR (AI) research process.

7.3 Cycle 2

7.3.1 Design (Plan) of the Mechanism

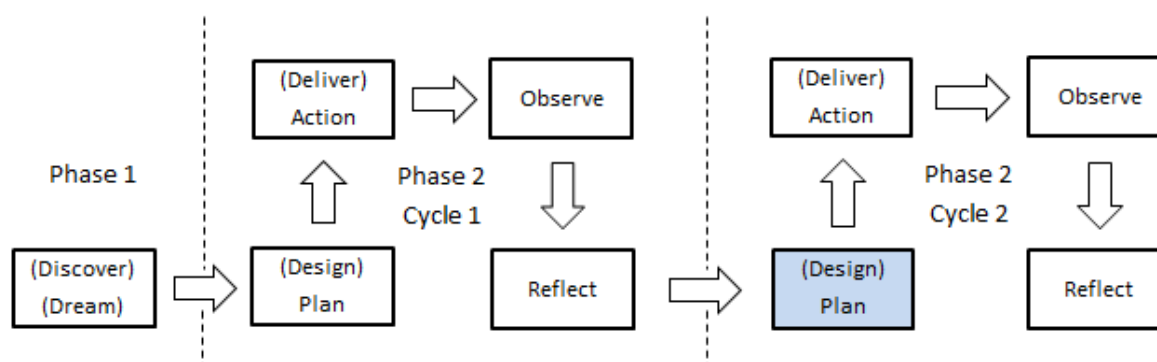


Figure 7.4: Where the development of the reporting mechanism fits into the methodological cycles (Phase 2 Cycle 2).

This stage of the AR cycle was to further develop the reporting mechanism based upon the evaluation data, patient safety reports and success of the piloting (in the form of distribution and response rates). The following section details the changes that were made to the reporting mechanism and the rationale for doing so, linking in with the findings from Cycle 1 of piloting. This takes the same format as the Design (Plan) stage from Cycle 1 of piloting, which was detailed in Chapter 6; development of the reporting mechanism. Any places where the reporting mechanism was changed are numbered in red and explained in the text below.


<p>What do we mean by safety?</p> <p>Safety can have many different meanings. From speaking with other service users and carers, we believe that to feel safe, healthcare professionals must:</p> <ul style="list-style-type: none"> • communicate with you, • respond to your individual needs, • ensure that you can trust them. <p>You should also be physically safe and secure, such as being free from:</p> <ul style="list-style-type: none"> • falls, • healthcare acquired infections, • medication errors. 	<p>Would you like to receive feedback?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please fill out your details below. All information will remain private and confidential in line with the Data Protection Act 1998, and will not be shared with anyone or used for any other purpose than to provide you feedback.</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Telephone: _____</p> <p>To find out if we are reaching everybody, could you please tell us your gender, age and racial / ethnic origin. You do not have to complete this part if you do not want to.</p> <p>Gender: Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Age: _____</p> <p>Racial / ethnic origin: _____</p>	<p>SAFE AND SURE</p> <p>Safety Survey 2</p>  <p>Dear patient / carer,</p> <p>This form is for you to tell us if you felt safe or unsafe in your most recent transfer, and what made you feel this way. Anything that you tell us will remain confidential and will not affect the care that you receive</p> <p>It is important for us to capture your experiences so that we can improve our services. Please complete the form and return it in the prepaid envelope provided.</p> <p>If you have any questions or would like help completing the form, contact Jason Scott on 0191 215 6722.</p>
<p>What do we mean by your transfer?</p> <p>Your transfer is an episode of healthcare when entering or exiting a health service. This includes planning and preparing for departure, the journey and settling in on arrival.</p>	<p>What to do if you want to make a complaint?</p> <p>By completing this reporting tool you are not making a complaint. Instead we are going to use the information you have provided to improve services. If you have felt unsafe at any other point during your care or would like to make a formal complaint please contact the Patient Advice and Liaison (PALs) team on 0800 953 0667.</p>	<p>1</p>
<p>NHS North East northumbria UNIVERSITY SAFER CARE NORTH EAST</p>		

Figure 7.5: Outside of the patient reporting mechanism v2.

Your Departure		3		Your Journey		Your Arrival																																																																																																	
Date of departure: _____ Leaving point: (please tick) • Community Care <input type="checkbox"/> • Home <input type="checkbox"/> • Hospital <input type="checkbox"/> • Nursing / Residential Home <input type="checkbox"/> • Other: _____				Method of transport: (please tick) • Ambulance <input type="checkbox"/> • Patient Transport <input type="checkbox"/> • Private Car <input type="checkbox"/> • Public Transport <input type="checkbox"/> • Taxi <input type="checkbox"/> • Other: _____		Destination: (please tick) • Community Care <input type="checkbox"/> • Home <input type="checkbox"/> • Hospital <input type="checkbox"/> • Nursing / Residential Home <input type="checkbox"/> • Other: _____																																																																																																	
Please tick which of the following affected how safe or unsafe you felt during your departure , including the preparation and planning . Leave blank if not applicable to you.		4		Please tick which of the following affected how safe or unsafe you felt during your journey . Leave blank if not applicable to you.		Please tick which of the following affected how safe or unsafe you felt on arrival , including settling in . Leave blank if not applicable to you.																																																																																																	
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Please use this space to state if there was another reason why you felt safe or unsafe or to expand on your answers above. 5																																																																																																							

Figure 7.6: Inside of the patient reporting mechanism v2.

Number 1: Removal of details for service users to provide further information

Following Cycle 1 of piloting, no service users had expanded upon their answers for why they felt either safe or unsafe. It was thought that providing space within the reporting mechanism would encourage responses, especially considering some service users had expanded on their answer for 'other' safety within the reporting mechanism. See Number 5 for the inclusion of the extra space.

Number 2: Change to the title of the reporting mechanism

The title of the reporting mechanism was changed from 'Sure Care Patient Safety Survey' to 'Sure Care Safety Survey'. This was done after the private nursing home manager provided feedback that the use of the term patient was not representative of the ethos of the study, in which the reporting mechanism may be completed by patients, family members, carers or advocates.

Number 3: Changes to the details of the service user's organisational care transfer information

Evaluation data and responses to the reporting mechanism suggested that the way in which information about the service user's organisational care transfer was captured was not always appropriate. Location and date were not always appropriate with most service users leaving them blank for all three stages of the organisational care transfer. This was understandable as the location in particular did not make sense for the journey, where service users would not have been in one individual place. Date was also duplicated as almost all organisational care transfers were conducted over a short space of time. Location was removed from the reporting mechanism for Cycle 2 of piloting, and a single space for the date was included.

Number 4: Changes to the reports on how safe or unsafe the service user felt

In addition to the six questions on safety, service user's rating of their overall safety was also added to this section. This was a result of the limited number of responses to the overall section in comparison to the other questions on safety. By incorporating into the other questions, it will be possible to determine if it was because service users did not want to report their overall safety, or if it was because it seemed disjointed from the rest of the reporting mechanism.

A further modification to this section was to increase the size of the text and the smiley faces, utilising the space that was obtained from the removal of the location and date sections. This was based on evaluation feedback where respondents sometimes had difficulty reading the text. Furthermore the yellow smiley faces were made to represent just a neutral feeling of safety rather than the mixture between neutral or not applicable. This was to remove any confusion that had arisen about what to do when questions were not applicable to the care that the service user received or the organisational care transfer that they had gone through. This was aided by the inclusion of an instruction in what to do when a question was not applicable.

Number 5: Inclusion of space for service users to expand on their answers

By moving the 'overall' question and embedding it with the rest of the questions, space was created for participants to expand upon their answers. This was in response to Pil01 who stated that there was a lack of space in which to expand on answers and tell their story. Although the patient reporting mechanism is not able to account for in-depth answers on the service user's organisational care transfer, it was possible to provide some space for free

text in which service users could expand on their answers rather than requesting that they enclose it on a separate page.

7.3.2 Delivery (Action) of the Mechanism

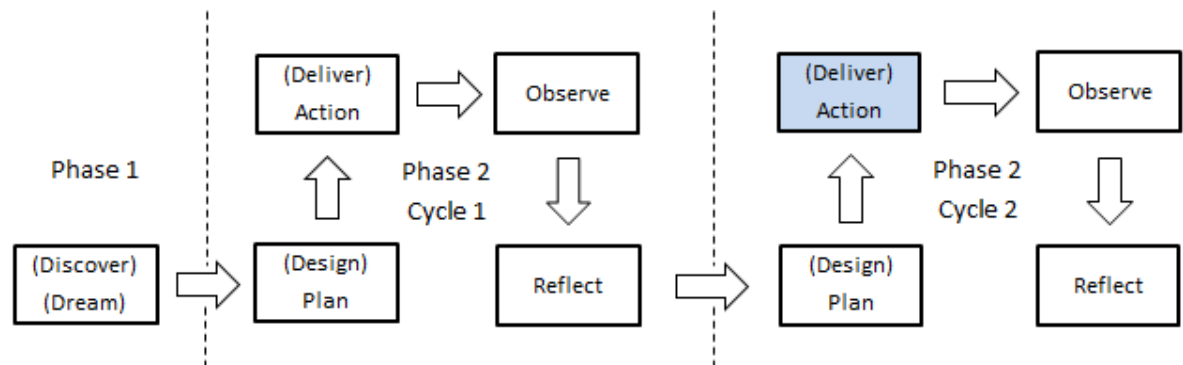


Figure 7.7: Where the (Deliver) Action stage of piloting fits into the methodological cycles (Phase 2 Cycle 2).

Out of the 120 reporting mechanisms distributed to the six organisations, 61 were distributed to service users. This is 30 fewer than Cycle 1 of piloting, where 91 were distributed. The largest difference was from the two social care homes, which were unable to distribute any reporting mechanisms due to organisational budget cuts and restructuring. One social care home closed shortly after being given the reporting mechanisms to distribute to service users. The other organisations faced similar issues during the piloting of the reporting mechanism, which had a larger impact on the collection of participant information than the distribution of the reporting mechanisms.

Organisation	Number Distributed	Response Rate
<i>NHS Community Care Team 1</i>	16 / 20 (80%)	1 / 16 (6%)
<i>NHS Community Care Team 2</i>	20 / 20 (100%)	7 / 20 (35%)
<i>NHS Community Care Team 3</i>	20 / 20 (100%)	9 / 20 (45%)
<i>Social Care Home 1</i>	0 / 20 (0%)	- / -
<i>Social Care Home 2</i>	0 / 20 (0%)	- / -
<i>Private Nursing Home</i>	5 / 20 (25%)	5 / 5 (100%)
Total	61 / 120 (51%)	22 / 61 (36%)

Table 7.9: Distribution rate from organisations to service users and response rates (Phase 2 Cycle 2).

The private nursing home reported a lower distribution rate due to a limited number of organisational care transfers into and out of the organisation. The lower distribution rate was also a result of targeting service users who were willing and able to participate, which resulted in the 100% response rate. No information was given on how many service users from the private nursing home refused or were unable to participate.

From the 61 reporting mechanisms distributed, 16 were given to patients, two were given to a family member or a carer and three were given to an advocate. Data for the other 40 reporting mechanisms is unavailable. The average age of service users that the reporting mechanism was distributed to, based on available data was 78 years, with 27 females and 12 males. Although data was collected on medical conditions, this was not extensive enough to be used in an exploration of the findings. 15 reporting mechanisms were given to service users on arrival into the service, whilst 6 were given on departure from the service.

Organisation	Distribution				
	Average Age	Male	Female	Arrival	Departure
NHS Community Care Team 1	75	5	11	-*	-*
NHS Community Care Team 2	-*	-*	-*	-*	-*
NHS Community Care Team 3	79	7	13	14	6
Social Care Home 1	-	-	-	-	-
Social Care Home 2	-	-	-	-	-
Private Nursing Home	90*	0*	3*	1*	1*
Total	78	12	27	15	7

*Denotes that some or all data is missing

N.B. Average age is rounded to 1 decimal place. Where the value is 0, it was not included in the Total calculation

Table 7.10: Description of who the reporting mechanism was distributed to by organisation (Phase 2 Cycle 2).

In total 22 (36%) people responded to the reporting mechanism. The average age of respondents was 78, four were male and nine were female. Nine respondents were given the reporting mechanism on arrival and three were given it on departure. These are broken down by organisation in Table 7.11.

Organisation	Respondents					
	Number of Respondents	Average Age	Male	Female	Arrival	Departure
NHS Community Care Team 1	1	67	-	1	-	-
NHS Community Care Team 2	7	-*	-*	-*	-*	-*
NHS Community Care Team 3	9	82	4	5	7	2
Social Care Home 1	-	-	-	-	-	-
Social Care Home 2	-	-	-	-	-	-
Private Nursing Home	5	90*	0*	3*	1*	1*
Total	22	83	4	9	8	3

*Denotes that some or all data is missing

N.B. Average age is rounded to 1 decimal place. Where the value is 0, it was not included in the Total calculation

Table 7.11: Description of who responded to the reporting mechanism by organisation (Phase 2 Cycle 2).

Where data was available, the ratios of respondents have been developed as a form of comparison between the respondents and the overall sampled population that the reporting mechanism was distributed to. The ratio of females to males that responded to the reporting mechanism (2.25) remained the same as who it was distributed to (2.25). However there was a difference between the ratio of respondents (2.67) who were given the reporting mechanism on arrival instead of departure in comparison to the distribution of the reporting mechanism (2.14). The average age of respondents (83) was also higher than the average age of those it was distributed to.

This suggests that gender does not impact upon the willingness or ability to respond. However in this cycle of piloting, there was a difference in the age of respondents. Given the low amount of data collected by healthcare professionals on who the reporting mechanism was distributed to, it is not possible to attribute this to age differences as it may have been an artefact of either the sampling or lack of data. For example the average age of respondents from the private nursing home (90) may have skewed the data away from the average age of who it was distributed to (79).

7.3.3 Observation

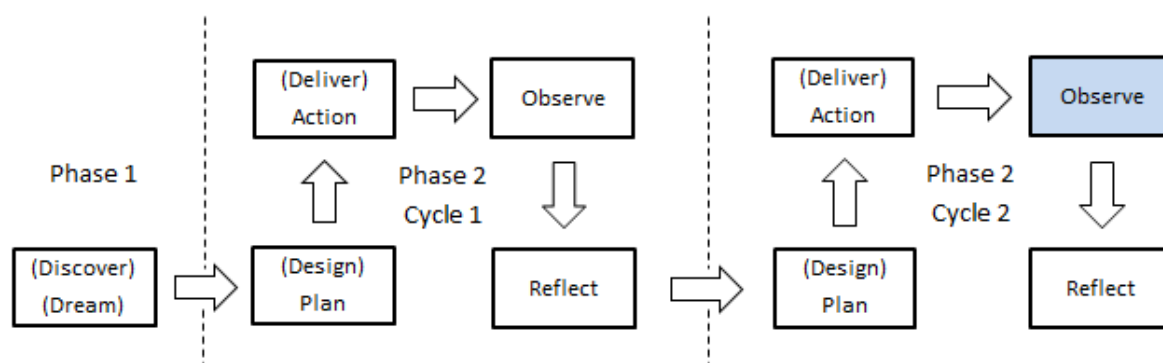


Figure 7.8: Where the Observation stage of piloting fits into the methodological cycles (Phase 2 Cycle 2).

When completing the reporting mechanism, service users were asked the location of their departure and arrival points (Hospital, Home, Nursing or Residential Home, Community Care or Other) as well as their mode of transport (Ambulance, Private Car, Taxi, Patient Transport or Other). A summary of responses is provided in Table 7.12.

Departure					
<i>Hospital</i>	<i>Home</i>	<i>Nursing or Residential Home</i>	<i>Community Care</i>	<i>Other</i>	<i>Unstated</i>
11	5	5	0	0	1

Journey					
<i>Ambulance</i>	<i>Private Car</i>	<i>Taxi</i>	<i>Patient Transport</i>	<i>Other</i>	<i>Unstated</i>
12*	6	2	2*	0	1

Arrival					
<i>Hospital</i>	<i>Home</i>	<i>Nursing or Residential Home</i>	<i>Community Care</i>	<i>Other</i>	<i>Unstated</i>
9	7	5	1	0	0

*One respondent selected both ambulance and patient transport

Table 7.12: Self-reported locations and journey types by respondents.

Service users reported their safety across a number of domains, each of which was based on the findings from Phase 1. As no new domains had been highlighted in the first cycle of piloting, these remained the same. The following section details how safe the respondents felt during their departure (Table 7.13), journey (Table 7.14) and arrival (Table 7.15). Where the totals do not equate to 22, data for that domain was either missing or was not applicable and therefore left blank by the respondent. Out of the 22 organisational care transfers that were reported on, six (27.3%) discrete respondents reported feeling unsafe in at least one domain.

For this cycle of piloting there was no 'other' question for each of the three stages of the organisational care transfer. Therefore there are only six domains of safety included in this cycle of piloting instead of the seven that were included in Cycle 1. To replace the 'other' question, a section was included at the end of the reporting mechanism for service users to provide any further information on why they felt safe or unsafe. Where possible, these comments have been placed in their appropriate stage of the transfer. Those that were not applicable to one specific stage of the organisational care transfer are presented in the 'Additional Comments' section that follows the reports of safety. The majority of these additional comments are by advocates who completed the reporting mechanism for the service user. In the same manner as Cycle 1 of piloting, the overall rating of safety was not included in any of the incident rate calculations or total number of incidents reported.

Departure

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
15	2	1	14	4	1	14	3	1	12	3	2

Medication			Hygiene			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
11	4	2	13	4	1	14	3	1

Table 7.13: Service user reports of safety during their departure (Phase 2 Cycle 2).

During their departure from services, respondents reported feeling safe a total of 79 times across the six domains whilst feeling unsafe eight times, with some respondents reporting feeling unsafe across more than one. The majority of respondents felt either safe or were neutral. Three discrete respondents reported feeling unsafe in at least one domain during their departure, giving an incident rate of 13.6% for the point of departure. One of the respondents that had reported feeling unsafe proceeded to report the same overall, another reported being neutral and the third reported feeling safe overall.

Journey

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
14	3	0	14	2	1	15	1	0	13	1	1

Medication			Hygiene			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
12	3	0	13	2	0	16	0	0

Table 7.14: Service user reports of safety during their journey (Phase 2 Cycle 2).

During the journey stage of the transfer, service users reported feeling safe 81 times and unsafe three times across the six domains. The three reports of feeling unsafe were made by two respondents, giving an incident rate of 9.1%. The majority of respondents felt either safe or neutral. No respondents reported feeling unsafe overall. The respondent that had felt unsafe regarding falls or potential falls reported feeling safe overall, whilst the respondent that felt unsafe regarding staff listening to them was neutral overall.

One service user expanded upon their answer with ‘Felt secure in ambulance – strapped in’ [224, Reporting Mechanism], suggesting that this had made them feel safe. Being strapped in does not currently fit with any of the current domains, so could potentially be a new domain added to later iterations of the reporting mechanism.

Arrival

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
16	1	1	12	3	2	10	4	4	13	2	1

Medication			Hygiene			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
12	5	1	9	5	2	12	5	1

Table 7.15: Service user reports of safety during their arrival (Phase 2 Cycle 2).

During their arrival, service users reported feeling safe 72 times and unsafe 12 times across the six domains, with some respondents reporting feeling unsafe across more than one domain. The majority of respondents felt either safe or were neutral. Five discrete respondents reported feeling unsafe in at least one domain during their arrival, giving an incident rate of 22.7%. Only one of these reported feeling unsafe overall, whilst the other four were neutral.

The service user that had felt unsafe overall gave an explanation for their answers.

- ‘Departure: Management twice daily of the arm halter with my left hand only available for tasks. Arrival: My abilities to dress / undress and wash hair etc. were problematic. A visit to the Dr’s surgery halted my concern with offer of home visit support’ [267, Reporting Mechanism]

This resonates closely with the story told by P06 from Phase 1 who was discharged from hospital without a care team in place when she was unable to care for herself due to having a broken arm. This justifies the need for space for respondents to either expand on their answers or to provide new information. It also highlights that the reporting mechanism is able to capture similar incidents to those from which it was based on. Although the reporting mechanism does not specifically target this issue of having adequate support on discharge, it could be tailored to do so when being piloted in organisations or teams to which it is

specific; in these cases either the hospital (if given on departure) or the community care team (if given on arrival).

Additional Comments

In the additional comments, three respondents expanded upon their answers to reaffirm why they had felt safe. P235

- ‘No problems this round trip for routine hospital checkup’ [P233, Reporting Mechanism].
- ‘Pre-booked transfer for arranged transport with home staff escort. Smooth journey. Efficient and to time transfer and return’ [P255, Reporting Mechanism]
- ‘Quick trip. Got cup of tea straight away when I get here’ [P236, Reporting Mechanism]

A further two respondents expanded upon why they had felt safe. Both of these were advocates for the patient who had been transferred out of the private care home to an accident and emergency department.

- ‘Resident fall - suspected fractured neck of femur. Ambulance staff refused assistance of home staff and equipment to manually lift resident from bed to wheelchair for ambulance transfer / resident manually lifted from wheelchair to ambulance stretcher for transfer to hospital. / long wait for resident to be seen in A&E x-ray and ward transfer’ [P234, Reporting Mechanism]
- ‘Ward telephone to inform resident transfer when resident had already arrived. No discharge letter. Home informed 'nothing to do with you' / Resident reports - home quickly but no breakfast (resident arrived at home 9.15am) / Resident received home as before. No discharge letter. Home telephoned ward to obtain verbal update. No written confirmation of verbal information until 48 hours later’ [P267, Reporting Mechanism]

7.3.4 Reflection

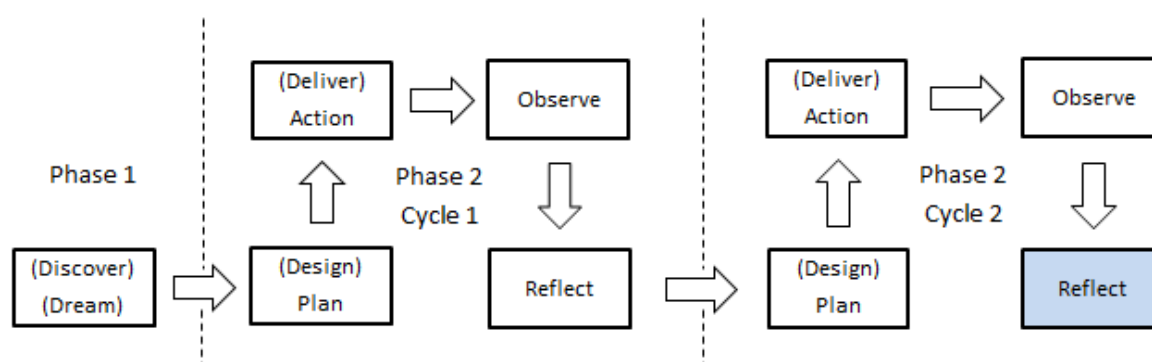


Figure 7.9: Where the Reflection stage of piloting fits into the methodological cycles (Phase 2 Cycle 2).

Evaluation data on Cycle 2 of piloting was collected through evaluation forms given to service users at the same time as the reporting mechanism. This was a modified version of the evaluation form given to service users in Cycle 1 of piloting (Table 7.16). Item 4 changed from 'The questions were appropriate' to 'The questions that were asked accurately captured what made me feel safe or unsafe' as it was felt that the former was ambiguous. Item 6 was included to determine if there were any barriers to service users completing the reporting mechanism. Items 7 and 8 were included in response to feedback from service users in Cycle 1 of piloting that they had found it difficult to complete either due to the text size or the use of the colours. All items included in the evaluation form in Cycle 2 are located in Table 7.16.

No respondents volunteered to participate in an interview. Not all respondents returned the evaluation form with the reporting mechanism, whilst out of those that did, some did not complete every question. Consideration was again taken when analysing the responses as there was the potential for self-selecting bias, especially as no service users returned the evaluation form without completing the reporting mechanism.

Item Number	Item	Agreed	Neither Agreed or Disagreed	Disagreed
1	I understood the purpose of the Safety Survey	14	3	0
2	I understood what was meant by 'your journey'	15	1	0
3	I understood each of the questions	14	2	0
4	The questions that were asked accurately captured what made me feel safe or unsafe	13	4	0
5	There was nothing missing from the Safety Survey	7	7	1
6	I experienced difficulties completing the Safety Survey	2	3	10
7	I felt that the colour scheme was useful	9	5	1
8	The size of the text was appropriate	10	3	2
9	The Safety Survey allows me to provide useful feedback about the healthcare I have received	13	3	0

Table 7.16: Answers to the nine items on the evaluation form (Phase 2 Cycle 2).

17 respondents completed and returned the evaluation form. For item 1, 14 agreed with this statement, and three neither agreed nor disagreed. No participants disagreed with the statement. These figures show a similar distribution as those in Cycle 1 of piloting, suggesting respondents were able to understand the purpose of the reporting mechanism, and that the purpose was clearly articulated. For item 2, 15 respondents agreed with this statement, one neither agreed nor disagreed and none disagreed. One did not select an answer. This was an improvement on the first cycle of piloting, where two respondents had disagreed with the statement. This may be reflective of the smaller sample, where given the same size sample as Cycle 1 it may have been expected that more people disagreed with the statement. However regardless of this, the high proportion that agreed with the statement again suggests that the term 'your transfer' is clear to respondents and would not need to be revised in the future.

For item 3, 14 respondents agreed, two neither agreed nor disagreed and none disagreed. Given that the questions had not been modified, this supports the conclusions from Cycle 1 of piloting that the questions were clear. This was a similar distribution to respondents in Cycle 1 of piloting, where 24 agreed, four neither agreed nor disagreed and none disagreed. For item 4, 13 respondents agreed, four neither agreed nor disagreed and none disagreed.

Respondents were not as positive about item 5, with only 7 agreeing with the statement, 7 neither agreeing nor disagreeing and 1 disagreeing. The participant that disagreed expanded upon their answer, reaffirming what they had written in the reporting mechanism. The implication of this is discussed in the summary.

- ‘My concerns re home care assistance should have been addressed at the hospital after my right arm operation. It was only suggested some 4 days later at my Dr's practice when the practice nurse observed my discomfort and concern’ [267, Evaluation Form]

Item 6 was a negatively weighted question. 2 respondents had difficulties completing the reporting mechanism, three neither agreed nor disagreed with the statement and 10 did not have any difficulties. One respondent (269) that reported having difficulties had left the reporting mechanism blank, with the exception of completing the date, leaving point, transport type and destination. They neither agreed nor disagreed with every other statement on the evaluation form, and did not expand on their answers. It is therefore not possible to determine what difficulties this respondent had in completing the reporting mechanism. The other respondent that reporting having difficulties also disagreed with item 8, suggesting that their difficulties were due to the size of the text. Despite this they still completed the reporting mechanism in full.

For item 7, nine respondents agreed that the colour scheme was useful, five neither agreed nor disagreed and one disagreed. For item 8, 10 felt that the text size was appropriate, three neither agreed nor disagreed and two disagreed. All that agreed with these two statements still completed the reporting mechanism in full, suggesting that for these respondents despite having difficulties it was still possible to complete the reporting mechanism. However based on evaluation data from both rounds of piloting, consideration needs to be given for service users who may have sight difficulties.

13 respondents agreed with item 9, with 3 neither agreeing nor disagreeing and none disagreeing. This is a similar distribution to Cycle 1 of piloting, where the numbers were 25, four and zero, respectively.

One other respondent expanded upon their answers, but instead of making evaluative comments they used the space to expand on why they had felt safe, which had already been captured in their reporting mechanism.

- ‘I received excellent care from urgent care nurses, the ambulance service and hospital treatment’ [196, Evaluation Form]

7.3.5 Summary of Cycle 2

The number of reporting mechanisms distributed by the healthcare professionals to service users was low (50.8%). The two social care homes had the greatest impact upon this, having not distributed any. The reason for this was that reforms to health and social care policy had impacted upon their services, resulting in them not having the available resources to continue participating in the study. There was also limited information from other organisations as to who the reporting mechanism was distributed to, again due to the reforms to health and social care that put a strain on their resources.

Despite the limited number of reporting mechanisms distributed to service users, the response rate was again acceptable, although on the lower end of the variance that is reported in the literature. There were no differences in gender of respondents that it was distributed to and who responded. However those that responded to the reporting mechanism were on average older than those that it was distributed to, and service users were more likely to respond to the reporting mechanism when it was given on arrival into, rather than departure from the service.

From the 22 reports on safety, service users were able to identify and report on feeling unsafe. These reports were varied depending upon the stage of the organisational care transfer; the discharge and journey displayed similar incident levels (13.6% and 9.1% respectively), whilst the number of incidents on arrival were much higher at 22.7%. These represent a slightly lower incident rate than in Cycle 1 of piloting, although it is likely to be as a result of the low distribution rate, especially from the two social care homes, rather than other extraneous variables.

The evaluation feedback from service users, collected solely via the evaluation forms, suggested similar levels of support for the reporting mechanism as Cycle 1 of piloting. The greatest finding from the evaluation form was that the size of the text may not have been appropriate for all service users, suggesting that future piloting and roll-out of the reporting mechanism should make it available in large print. This is especially of importance when given to elderly people who are more likely to have poor eyesight or other conditions that make reading small print difficult.

7.4 Collated Results

In addition to the individual rounds of piloting, it is also possible to collate the results together to give a wider overview of safety as reported by service users. This is possible as a result of using the same questions in both rounds of piloting, although 'other' was moved into free-text in Cycle 2. Consequently the 'other' section has been removed from the collation as it has already been reported previously. The evaluation is not repeated in this section as many of the questions changed and there is no value in repeating these.

Departure

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
43	6	3	41	11	2	35	12	5	33	13	4

Medication			Hygiene			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
34	13	5	37	12	2	34	3	3

Table 7.17: Service user reports of safety during their departure (Phase 2 Cycle 2).

During their departure from services, service users reported feeling safe 223 times and unsafe a total of 24 times across the six domains, with some respondents reporting feeling unsafe across more than one. The majority of respondents felt either safe or were neutral. 12 discrete respondents reported feeling unsafe in at least one domain during their departure, giving an incident rate of 19.05% for the point of departure.

Journey

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
42	7	2	41	9	2	36	10	4	34	11	3

Medication			Hygiene			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
35	12	3	37	10	1	36	0	2

Table 7.18: Service user reports of safety during their journey (Phase 2 Cycle 2).

During their journey, service users reported feeling safe 225 times and unsafe 17 times across the six domains, with some respondents feeling unsafe across more than one domain. These were split between seven respondents (11.11%), who reported feeling unsafe at least once across each of the seven domains. The majority of respondents felt either safe or neutral.

Arrival

Communication from staff			Staff listening to you			Departure running to schedule			Falling or Potential Falls		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
44	5	3	29	10	3	31	13	8	34	12	3

Medication			Hygiene			Overall		
Safe	Neutral	Unsafe	Safe	Neutral	Unsafe	Safe	Neutral	Unsafe
35	14	4	33	13	3	32	5	3

Table 7.19: Service user reports of safety during their arrival (Phase 2 Cycle 2).

During their arrival, service users reported feeling safe 206 times and unsafe a total of 27 times across the six domains, with some respondents reporting feeling unsafe across more than one domain. The majority of respondents felt either safe or were neutral. 11 discrete respondents reported feeling unsafe in at least one domain during their arrival, giving an incident rate of 17.46%. An overview of the collated results is provided in the following section, the summary of the chapter.

7.5 Chapter Summary

The findings of each cycle have been summarised individually previously (7.2.4 and 7.3.5 respectively). The reports from each cycle have been collated and reported in 7.4. This section presents comparisons between the two and an amalgamation of the findings where appropriate to provide aggregated results.

There was a large difference in the number of reporting mechanisms that were distributed to service users, with 91 distributed to service users in Cycle 1 of piloting in comparison to 61 distributed in Cycle 2. The two social care homes that dropped out of the study due to health and social care reforms made the largest impact upon this number, whilst NHS community care team 1 had similar issues, although they still managed to distribute the majority of their reporting mechanisms. Other impacts that the reforms had on the piloting of the reporting

mechanism were that the healthcare professionals from two of the NHS community care teams were unable to complete the form detailing who the reporting mechanisms had been distributed to. As such it was not possible to provide a direct comparison between the two rounds of piloting, for example between the response rates to determine if there were differences based upon the changes made.

Despite this, a large enough number of reporting mechanisms were distributed to service users to determine if there was interest in the reporting mechanism and to determine if service users were able to report on their safety. This was achieved by aggregating the data from the two rounds of piloting together, which was made possible by collecting the same information on safety. From both rounds of piloting, 19 out of 63 (30.16%) respondents reported feeling unsafe in at least one domain of safety across the three stages of the organisational care transfer. Therefore service users within this study felt unsafe during the organisational care transfer to a greater extent than is currently reported in the literature. A wider discussion of the implications of this finding is presented in the discussion chapter.

Furthermore, service users across both rounds of piloting were more likely to respond to the reporting mechanism when it was given on arrival into the service than on departure from the service. There are two potential explanations for this outcome. Firstly, healthcare professionals may have been in a position to provide reminders to service users to complete the reporting mechanism. Although the quantity of reminders is speculative, literature supports the notion that providing service users with one or more reminder is likely to significantly increase response rates (McColl, et al., 2001). Secondly, service users may have felt obliged to complete the reporting mechanism whilst still under the care of their healthcare team. Healthcare professionals were asked to inform the service user that participation was voluntary and the process of returning the reporting mechanism via a free postal service supported this. However some service users may have still believed that there was an implicit requirement to complete the reporting mechanism.

With regards to perceptions of safety reported by service users under the domain of 'other', there were very few that were not already captured in the reporting mechanism. One perception of safety that was missing was the lack of care support put into place on discharge from hospital to home. This was a similar scenario to that depicted by P06 in Phase 1, and constitutes a lapse in the systems used to identify post-discharge care requirements. Within this study this issue is only of relevance to the NHS community care teams and not the social care or private nursing homes. This provides a reminder that the reporting mechanism may need to be tailored to the organisations in which it is to be utilised,

as different types of care transfers may exhibit difference characteristics or components of safety.

The evaluation data suggested that the reporting mechanism works and participants generally agree that they understand it, the questions were appropriate and it allowed them to provide useful feedback about their healthcare. However the potential responses from non-respondents need to be taken into consideration as it is possible that the service users who disagreed with these statements are the ones that did not respond. Effort was made to capture these responses through asking people to return the evaluation form even if they did not complete the reporting mechanism. However during Cycle 1 of piloting nobody did this, whilst during Cycle 2 of piloting, one respondent (212) completed the evaluation form without the reporting mechanism, and agreed with all statements except 'I felt that the colour scheme was useful', to which they neither agreed nor disagreed.

Chapter 8: Discussion

8.1 Chapter Overview

The final chapter of this thesis will firstly discuss the main findings of the study. The aims and objectives are restated in order to address how these were answered, reflecting the way in which the findings are reported in the previous three chapters, providing a chronological order to the development of the reporting mechanism. This begins with the patient perceptions of safety, which were integral to all further aspects of developing and piloting the reporting mechanism. Following this, the actual development of the reporting mechanism and the results of piloting the reporting mechanism are reported individually.

The findings from these three stages and phases will then inform a theoretical and policy-driven discussion of patient reporting of safety within organisational care transfers, followed by implications for practice. The chapter ends with an overview of the limitations of this study, potential areas for future research and concluding remarks.

8.2 Discussion of Findings

8.2.1 Aims & Objectives

The aims of the research were to investigate service user perceptions of safety and to develop a method of facilitating service users to identify and report self-defined patient safety incidents in a care transfer setting, as defined by the Patient Safety Strategic Framework (NHS North East, 2008). To achieve these aims, the research was structured into two phases each with individual methodologies. The objectives of each phase are outlined below.

Phase 1

- Explore the concepts, explanations and terms used by service users when talking about safety in organisational care transfers,
- Explore what safe care feels like to service users in organisational care transfers,
- Define patient safety in organisational care transfers from service users' perspectives,

Phase 2

- Create a reporting mechanism that would facilitate service users to report on their self-defined safety when going through an organisational care transfer.

8.2.2 Phase 1: Patient Perceptions of Safety

8.2.2.1 Overview of Findings

In response to the aims and objectives relating to Phase 1 of the study, the findings identified the concepts, explanations and terms used by service users when talking about their safety within the context of organisational care transfers. These were reduced into an operational definition of safety within organisational care transfers that was utilised throughout the rest of the study, in particular in the development of the reporting mechanism.

Service users that participated in this study discussed safety around three key themes; communication, responsiveness and traditional safety issues. In addition to these three key themes, there are also other issues that were of importance to service users. These included the role that trust plays in relation to how patients perceive and define safety, and participant attitudes towards safety and the reporting of safety.

The communication theme consisted of five components which spanned two levels of sub-themes. These included healthcare professionals apologising after an incident, being friendly and reassuring, listening, providing a means to contact them and keeping the service user informed. With the exception of apologising, each of the components has an additional layer. Being friendly and reassuring included being civil and respectful and having somebody to talk to when going through the organisational care transfer. Listening was linked to having a choice, which in turn linked into the second theme of responsiveness. Having a means to contact a healthcare professional included either having contact details, in the case of those service users recruited from and in the care of the NHS community care teams, or having an alarm that links in to a healthcare professional in case of emergency. Being informed consisted of being able to understand instructions, being kept updated throughout the transfer, healthcare professionals fully identifying themselves and having the knowledge that support is in place prior to a transfer; in particular when being discharged home. Each of these contributed to the service user feeling safe when being transferred.

8.2.2.2 Relationship to the Current Literature

The Phase 1 findings show that service users define safety differently to healthcare professionals when going through organisational care transfers by including communication and responsiveness as being important concepts relating to their safety, along with the traditional safety issues of falls, HCAIs, drug incidents, missed diagnosis and inadequate care.

Where previous literature on service user perceptions of safety has focused on perceptions within hospitals (Burroughs, et al., 2005; Burroughs, et al., 2007; Masso Guijarro, et al., 2010) or primary care (Kuzel, et al., 2004), the findings within this study provide an insight into patient perceptions of safety when going through an organisational care transfer. The perceptions of safety in the above articles share many similarities to the findings of this study. Service users in the studies by Burroughs et al. (2005; 2007) shared concerns around medication errors, misdiagnosis, falls, staff not taking the time to listen to patients and not being responsive to patient requests. Similarly, service users in the study by Kuzel et al. (2004) focus on breakdowns in communication and relationship with their provider along with technical (traditional) errors. Each of these resonates closely with the themes identified within this study.

However there are also distinct differences in the reported perceptions. Burroughs et al. (2005; 2007) included problems with medical equipment, mistakes by nurses and physicians, being mistaken for another patient and having the wrong test or procedure conducted also impact upon safety, whilst Kuzel et al. (2004) included a breakdown in access and inefficiencies of care.

Based on these similarities and differences, it would appear that patient perceptions of safety differ depending upon the healthcare setting in the same manner that healthcare professional definitions of safety differ. For example venous thromboembolisms and bed sores are not applicable safety incidents to primary care where patients do not spend a lot of time in one location. The key themes identified in this study; communication, responsiveness and traditional safety issues are discussed individually in relation to the wider literature on patient safety and why they may be of importance to making patients feel safe.

Communication

As a general component of safety, communication has received much attention in the literature. The emphasis is placed upon the role of communication between healthcare professionals, such as the transfer of patient information (Kripalani, et al., 2007) or the role of teamwork that is associated with human factors (Kerr, 2009; Tjia, et al., 2009; Whyte, et al., 2009). Within this study, patients did not approach communication from a provider's perspective, instead focusing on the communication between their healthcare professional and themselves.

The sub-theme of 'being friendly and reassuring' relates to the personality types of healthcare professionals and their interaction styles with their service users. Kuzel et al. (2004) indicated a similar perspective of safety, though they classified it as a relationship breakdown rather communication. The largest proportion of relationship breakdowns related to disrespect or insensitivity, which shares many similarities to 'being friendly and reassuring', although on the opposite end of a continuum where a relationship breakdown is significant of being unsafe, whereas 'being friendly and reassuring' is indicative of being safe and a reflection of the AI.

Similarly, Hovey et al. (2011) and Burroughs et al. (2007) have identified that communication and relationship with their healthcare provider impacted upon the patient's experience of safety. The importance of this component of communication is already recognised, as can be evidenced in the training of future healthcare professionals (Warmington, 2011). However despite this, healthcare professionals still sometimes exhibit inadequate concern or insensitivity towards the patient (Frank, 2002).

The sub-theme of 'being informed' related to the information that was provided to service users and its accessibility. This can be seen to be of particular importance when service users are being transferred as there can be confusion and uncertainty about the organisational care transfer, such as what facilities or healthcare provision would be available on arrival, and the length of the organisational care transfer. This differed to the components of safety identified by service users in primary care (Kuzel, et al., 2004), hospitals (Burroughs, et al., 2005; Burroughs, et al., 2007) and with healthcare in general (Hovey, et al., 2011); perhaps representative of the organisational care transfer setting.

Likewise the sub-theme of 'having a means to contact a healthcare professional' can also be seen as being dependent upon the organisational care transfer setting. This finding represents the concern that patients have when their care has been transferred into a new, unfamiliar care setting, such as when returning home or going into a nursing or social care home. It can be argued that a feeling of security and safety is achieved through being in close contact with someone that is able to provide that required level of safety. When this close, direct contact is unavailable, it may be possible for it to be recreated through technological links; in this study via personal alarms linked to healthcare teams or a telephone.

Another sub-theme of communication was that of apologising if something had gone wrong, which would make service users feel safer in the future. Current healthcare policy suggests

that an apology should be given as soon as possible after an incident has occurred (NPSA, 2005). This policy goes beyond apologising, encouraging a culture of openness where a full, honest explanation is provided to the patient. This full disclosure is seen as one of seven pillars that are essential in responding to a patient safety incident (McDonald, et al., 2010).

It is thought that being open can reduce the psychological and emotional impact of a patient safety incident (Allan & McKillop, 2010; National Patient Safety Agency, 2005), whilst also reducing the chances of litigation (Vincent & Coulter, 2002). According to McDonald et al. (2010), apologising constitutes a second pillar, where remedial actions are proposed to reduce the chances of the same incident occurring again. These are distinguished from disclosure of an incident, as an apology should only be given when there is an admission of unreliable care. However in the UK, it is recommended that an apology is given when any patient harm occurs, regardless of severity or cause of the harm.

The finding in this study that apologising is a key component to making people feel safe expands upon the known impacts of apologising after an incident. The participants in this study did not discuss the importance of full disclosure or the need for remedial actions, instead focusing specifically on the need for communication in the form of an apology. Therefore it is suggested that an apology alone can make patients feel safer, although it may also impact upon their psychological and emotional wellbeing as well as reducing the chances of future litigation.

The final sub-theme within communication is listening. This relates closely to patient-centred care and responsiveness, and is therefore discussed in the following section.

Responsiveness

The components of the theme of responsiveness related to patient-centred care, where the patient and their needs are placed at the heart of the care process. One key point needs to be clarified when discussing patient-centred care; there is a general misconception that patient-centred care requires the sharing of all information and decisions (Stewart, 2001). Instead, the patient's desire for information is taken into account and responded to, meaning that those who do not wish to be involved in the decision-making process need not be.

The first of the components is that of 'listening', which also falls within the communication theme. It is reported here in the responsiveness rather than communication, as although listening is important to communication, it is essential to responsiveness; without listening to

the service user it is not possible to react to their needs and requirements, or to provide patient-centred care.

Listening to service users is not a new approach in itself, with the Patient Charter (Department of Health, 1992) originally indicating that service users should be listened to, which received support in an editorial in the British Medical Journal written by Smith (1993). Within this study, the theme of responsiveness also consists of making the organisational care transfer an easy process whilst responding to the individual needs of the service user, providing personalised care depending upon their condition. Again these are not new concepts in themselves as approaches to providing quality care. Patient-centred care can be said to fall within the acceptability component of quality, defined by Donabedian (2003) as 'conformity to the wishes, desires and expectations of patients and their families'. However by applying these components of responsiveness or patient-centred care to safety, they can also form effective healthcare. Going beyond patient-centred care to patient and public involvement, research by Rise et al. (2011) has suggested that patient and public involvement is founded on mutual respect. One key component of patient and public involvement, highlighted by both service users and healthcare professionals is that of respect, dialogue and communication (Rise, et al., 2011).

The theme of responsiveness expands beyond providing patient-centred care to also include waiting times. These were indicated by service users to impact upon how safe they felt. Although a full explanation was not given as to the reason why waiting times made people feel unsafe, the finding does resonate closely with the literature. For example Ackroyd-Stolarz et al. (2011) identified that in older people, a prolonged stay in the emergency department of a hospital is associated with an increase in the rate of adverse events as a result of overcrowding. Any reduction in waiting times and overcrowding reduced the number of incidents. Although service users in this study discussed short-term waiting times, for example waiting to be seen on arrival to accident and emergency, longer waiting times for specialist diagnoses or surgery can also have physical and psychosocial impacts on service users (Robling, et al., 2009).

Waiting times themselves have received much attention within healthcare policy, with service users being given "the right to access services within maximum waiting times" (Department of Health, 2010c, p. 8). However with the introduction of the white paper, *Equity and Excellence: Liberating the NHS* (Department of Health, 2010a), the focus on waiting times has been reduced in an attempt to focus on healthcare outcomes. The findings that waiting times are of importance to service users feeling safe suggest that attempts should be

made to keep them low, in keeping with the focus on healthcare outcomes. Furthermore, the concept of opening up the private sector to reduce waiting times has been found to be unsuccessful, with the only outcome being to reduce the capacity of the public sector with no impact on waiting times (Duckett, 2005). A wider discussion of the political and policy implications of this study is provided in the conclusion chapter.

Traditional Safety Issues

There are a number of types of iatrogenic illnesses that are widely recognised and reported upon in the healthcare literature, such as nosocomial infections (e.g. Barrett-Connor, 1972), medication errors (e.g. Liu, Manias, & Gerdzt, 2011) and surgical errors (e.g. Hurlbert & Garrett, 2009). Within this study, the service users interviewed were able to identify a number of these traditional safety issues. As the interviews were appreciative, the majority focused on the avoidance of these traditional safety issues, including falls, medication difficulties, healthcare acquired infections, missed diagnosis, painful procedures, physical safety and the provision of adequate care.

The majority of these have already been widely identified in the literature as being of importance to safety. For example, Knight et al. (2011) were able to identify that elderly people being discharged from hospital and their carers can often be confused with regards to the management of medication, which can potentially lead to an adverse event. Likewise falls have also received a great amount of attention. They have been identified to be the largest category of reported adverse events in hospitals (National Audit Office, 2005), however Davenport et al. (2009) highlight that service users experiencing a fall in hospital are at high risk of experiencing a fall post-discharge.

Noticeably most of the traditional safety issues identified by service users in this study are also applicable to most other areas of healthcare, not just organisational care transfers, although the degree to which they are relevant changes upon care setting. The only issues that are specific to organisational care transfers are those within the sub-theme of physical safety, which comprise of careful driving and personal security. Within the literature these have received little attention, which is representative of a lack of research being conducted into service user perceptions of safety within organisational care transfers.

Within this study the use of the term 'traditional safety risks' may be construed as being a catch-all theme to which there is no conceptual structure. This was done so as to represent that patients are able to identify many of the same hazards as clinicians. This concordance

between patient and medical definitions has been demonstrated in other studies (Burroughs, et al., 2005; 2007; Kuzel, et al., 2004; Masso Guijarro, et al., 2010). The findings from Phase 1 provide further evidence for this concordance, and support the notion that patients are able to identify and report these traditional safety risks. However it is necessary to remember that this is dependent upon individual circumstances of patients, as some may not be able or willing to report on their safety (Davis, et al., 2007; Davis, Sevdalis, & Vincent, 2011).

These themes developed during Phase 1 resonate very closely to research by Hovey et al. (2011) who identified three key themes that patients discussed in relation to unsafe care; loss of voice, loss of trust and the need to recover patient-centeredness. Although conceptualised slightly differently from the findings of this study, partly due to a focus on unsafe rather than safe care, the themes share strong similarities and consist of many of the same components. By applying these themes to a person-centred planning approach to healthcare, Hovey et al. (2011) propose that a model for safety can be developed that makes the patient the focal point of care and safety. A similar approach can be seen within this study where the reporting mechanism developed in Phase 2 performed in a similar manner; making patients the focal point in the identification and reporting of their safety.

To do this, Hovey et al. (2011, p. 670) highlighted that 'through the explication of multiple perspectives, hermeneutical inquiry creates a different or new way of understanding a topic'. However such an approach does not give an explanation of the links to the complex nature of safety in an ontologically single reality. The use of critical realism within the current study gives a similar allowance for multiple perspectives via the transitive dimension of reality, but eventually links into the intransitive dimension, providing a clearer link to the underlying causal mechanisms that constitute reality.

A study using vignettes to compare healthcare outcomes, either positive or negative, with the relationship that the patient has with their care provider has suggested that the relationship itself has a greater impact on overall ratings of care than the healthcare outcome (Lawton, Gardner, & Plachcinski, 2010). Although this study was only conducted with mothers using hypothetical vignettes based on ante-natal care, the findings resonate closely with those of this study. In particular, the findings from Phase 1 suggest that communication, responsiveness and trust were all linked to how safe or unsafe the service users felt. These themes could be interpreted to be linked closely to the service users' relationship with their healthcare provider, especially in the case of trust. Despite these similarities, there are still large discrepancies; mothers in an ante-natal setting are likely to have a much greater

relationship with their healthcare provider than service users going through an organisational care transfer.

Additional Findings

In addition to identifying what had made service users feel safe during their organisational care transfer in concordance with the aims and objectives of the study, a number of other findings were identified from the interviews.

The findings on the attitudes that patients exhibited towards both safety and the reporting of safety provided a unique insight into how people perceived safety when going through an organisational care transfer. There were mixed attitudes to both, with some participants indicating that safety had not previously crossed their mind, whereas other participants reported that the thinking of safety was situation-dependent, where it would only occur in circumstances that allowed it. This has been a relatively unexplored field within patient safety, where the majority of research has focused on patient attitudes to being involved in safety, rather than how often they think about it. In particular there has been no research known to the author that explored this within the context of safe care, rather than unsafe care.

Research with similar findings has explored patient willingness to be involved in their own safety. For example Davis, Sevdalis and Vincent (2011) found that patients were willing to be involved in their own safety depending upon the situation and the profession of the healthcare professionals. Similarly Davis et al. (2007) found five factors that influenced patient involvement in safety; patient-related, illness-related, healthcare professional-related, healthcare setting-related and task-related. Participants within this study fall directly within the former two factors; patient-related and illness-related. This is evident in the emphasis that participants placed on trust, where safety is not contemplated due to their individual attitudes, or where they state that safety is only an interest when they are well enough to consider it. A further consideration is that patients are sometimes unaware of the risk that healthcare poses (Burroughs, et al., 2005; Evans, et al., 2006).

Further to these attitudes to safety, many participants also disclosed their attitudes to the reporting of safety incidents. Again there were mixed attitudes, although these were perhaps an artefact of the processes of AI that formed the questions and the recruitment strategy. For example when dreaming of what may be, some participants stated a willingness to report their safety. However when discovering past experiences, participants stated that they had

had no reason to report safety. It is therefore plausible that the perceived lack of interest in a reporting mechanism was formed by positive experiences of care where they had had no reason to report safety. Although this is a limitation, it was not strong enough to impact upon Phase 2. However there is clear scope for future explorations into the potential impact that this may have on patient and public involvement in the reporting of safety.

Asking participants about reporting positive experiences of safety as well as negative experiences posed an unusual situation in which some participants appeared to be unable to perceive the usefulness. Instead of discussing the reporting of positive experiences, they defaulted to discussing what would happen during a negative experience. This is perhaps an outcome of a large focus in both the media and healthcare policy that focuses on unsafe care and to a greater extent the traditional approach to safety of trying to correct mistakes rather than building on what works well, as required by AI.

Overall the concept of patient reporting of safety incidents within the literature is limited (King, et al., 2010). Wasson, MacKenzie and Hall (2007) explored patient reporting of safety through an internet-based survey capturing adverse events and found that patients were willing to report their safety. There are no studies known to the author that have directly explored general attitudes to the reporting of safety incidents, perhaps because very few organisations have implemented such reporting and feedback mechanisms. However there is an increasing body of research exploring the reliability of patient reports of safety, suggesting that where appropriate, patients are able to act as a safety buffer (Davis, et al., 2007) and report on their own safety (Masso Guijarro, et al., 2010). This research in combination with the findings from Phase 1 provided a strong rationale for the development of the reporting mechanism.

In addition to attitudes to safety and the reporting of safety incidents, another additional finding was that trust was often discussed by service users in relation to their safety. Service users were quick to state that having trust in their healthcare professionals was important to them feeling safe. There was an element of unconditional trust for healthcare professionals, although this did not always extend to the organisations that they operated within. For example where service users indicated that they had felt unsafe, it was not due to the healthcare professional's actions but rather due to external factors, such as a lack of resources. This finding opposes research that states that trust is never 'blind trust', but rather conditional (Skirbekk, et al., 2011). One potential explanation for this is due to the differences in care settings across the two studies. The majority of studies exploring trust (e.g. Skirbekk, et al., 2011) do so within a primary care setting during a consultation, and so

any differences may reflect trust within an organisational care transfer setting, where service users are sometimes seen as passive rather than active recipients of care.

The role of trust within safety has previously been seen to be an outcome of a patient safety incident, with patients potentially losing trust in their clinicians as a result of a safety incident (Quick, 2006), although this has been contested (Entwistle & Quick, 2006). The role of trust within Phase 1 was twofold. Firstly, participants often made excuses for clinicians, possibly as a result of cognitive dissonance; a feeling of unease when considering the people trying to help them may in fact harm them, or it could be alluding to their ability to identify latent conditions, e.g. resource limitations that have the potential to result in adverse events. If the last point is correct it supports the notion that patients can play a role in identifying and reporting safety incidents (Masso Guijarro, et al., 2010; Schwappach, 2008; Weissman, et al., 2008). Secondly, trust helped to make patients feel safer, potentially acting as a hindrance to their involvement in their own safety. It is therefore conceivable that trust may be both a mitigating factor and outcome of safety, although the exact interactions need further exploration.

8.2.3 Phase 2: Development and Piloting of the Reporting Mechanism

8.2.3.1 Development

During the two workshops, a number of different potential reporting mechanisms were identified and suggested by service users, including service user meetings, generic open-ended questionnaires, one-to-one interviews, verbal reports, Patient Advice and Liaison service (using service user complaints) and leaflets. Out of these, participants felt that a questionnaire and / or a leaflet were the most appropriate method of capturing patient reports of safety. Due to time and resource constraints there was only scope to develop and pilot one suggestion, meaning that in the second workshop a leaflet was the favoured type of reporting mechanism to be developed.

Although other suggestions were viable options for service user reporting mechanisms, the questionnaire was developed in the form of a leaflet based on the support that it received from service users and healthcare professionals. It also provided the greatest flexibility and could obtain the greatest amount of service user reports using the minimum amount of resources, along with having the capability to be embedded into organisations once the study had been completed. Other methods of collecting patient reports of safety, such as interviews, service user meetings and verbal reports did not contain these characteristics, although participants were not necessarily aware of these limitations. The use of PALs to

collect service user reports of safety would have simply duplicated existing methods of identifying safety incidents (e.g. Department of Health, 2009a; Jonsson & Ovretveit, 2008).

When exploring what the reporting mechanism should look like in Workshop 1, participants also identified key principles that should underpin the reporting mechanism. Key principles highlighted by participants were that the reporting mechanism needed to be patient-centred, short and concise with clear signposting, optionally anonymous and have a focus on both safe and unsafe care. These features were carried over into Workshop 2 and subsequently included in the reporting mechanism.

The reporting mechanism that was eventually developed, the safety survey, is similar in composition to other methods that have been reported to capture service user experiences of safety. King et al. (2010) have conducted the most extensive review of service user reports of safety to date, and found that three studies (Agoritsas, Bovier, & Perneger, 2005; Schwappach, 2008; Solberg, et al., 2008) used a written questionnaire to capture service user reports of safety. Of note, these studies only explored service user reporting of safety within individual healthcare settings including primary care (Schwappach, 2008), primary and speciality care (Solberg, et al., 2008) and in a hospital (Agoritsas, Bovier, & Perneger, 2005). Other forms of surveys have also been popular methods, such as web-based surveys, newspaper surveys and telephone surveys (King, et al., 2010).

These studies did not indicate how the survey was developed, suggesting that the use of Participatory AR within this study to involve service users and the healthcare professionals that would be responsible for piloting the reporting mechanism is a unique approach to developing a service user reporting mechanism. The two workshops consisted of collaborations between healthcare professionals and service users, working towards a single objective of developing a service user reporting mechanism. Collaborative, or partnership working between patients and healthcare professionals has been increasing, however concerns have been reported around the extent that patients' perspectives are included in the outcomes of such partnerships (Elberse, Caron-Flinterman, & Broerse, 2011).

The themes of safety within the final reporting mechanism were developed based upon the patient perspective, and the development of the reporting mechanism had an equal weighting between the patients and the healthcare professionals. For example once the reporting mechanism had been constructed following the two workshops, both the healthcare professionals and service users were asked to provide feedback and to highlight anything that may have been missing from the two workshops. This was particularly

necessary as for a patient reporting mechanism to be successful, there needs to be a high degree of saliency, which is best achieved through working closely with patients so that the reporting mechanism is based upon their needs and requirements. It can actually be argued that a limitation of this study is the reverse of Elberse, Caron-Flinterman and Broerse (2011), where the collaboration did not take into account the healthcare professionals' perspective as much as it should. A wider discussion of this and other limitations associated with using a survey are discussed in 8.2.3.3 in conjunction with the findings from the piloting of the reporting mechanism.

During the two workshops, in particular in Workshop 1, participants also explored practical issues of implementing the reporting mechanism. It needed to comply with current processes that are already in existence within each of the services. It was also identified that there are already numerous feedback mechanisms for when care is already in place, but there are no mechanisms for the admission and discharge processes within the organisations represented in this study. Discussions around the distribution of the mechanism focused on an individualistic approach in that it should be given to service users after each episode of healthcare. However there were uncertainties around if this should be via continuous distribution or batch distribution, depending upon available financial and time resources.

It was felt that legislation would be necessary as a driver to implement the reporting mechanism on a wider scale, with funding issues focusing on any potential advertising of the reporting mechanism and a sustained roll-out. The final issue of implementing the reporting mechanism discussed by participants was who the responsibility for monitoring and acting upon the reports rested with. These two points are discussed in greater detail in 8.5 where the role of commissioning is discussed in relation to obtaining service user reports of safety.

8.2.3.2 Piloting

Two rounds of piloting the reporting mechanism were conducted, each constituting one AR cycle. In each cycle of piloting, 20 reporting mechanisms were distributed to each of the six organisations that were involved in the development of the reporting mechanism; three NHS community care teams, two social care homes and a private nursing home. The reporting mechanisms were then distributed by the healthcare professionals to service users that they identified as fulfilling the recruitment criteria.

From the piloting of the reporting mechanism three major outcomes were explored; the types and frequencies of incidents reported by service users, the distribution and response rates

from service users and the evaluation of the reporting mechanism. The following section details each of these three individually along with a description of how the latter two link in together.

Distribution Rates

Before exploring the types and frequencies of incidents reported by service users, it is necessary to discuss the distribution and response rates of the reporting mechanism as they invariably impacted upon who did or did not provide reports of safety.

Distribution rates by the healthcare professionals were relatively high during the first cycle of piloting, with 76% of all reporting mechanisms distributed to service users. In addition, the majority of healthcare professionals were able to complete the required form that records who the reporting mechanism had been distributed to. During the second cycle of piloting the distribution of the reporting mechanism was substantially lower, with 51% of all reporting mechanisms distributed to service users. The information that healthcare professionals were asked to collate on who the reporting mechanism was distributed to was often lacking during this cycle of piloting, suggesting that engagement with the research study had reduced despite being given longer to distribute the reporting mechanism.

This represented a large change between the two rounds of piloting, and one that can be explored with theories of organisational development. Although this study primarily looked at patient perceptions of safety within organisational care transfers and the development of a reporting mechanism based upon these perceptions, the role of organisational development also played a key role. Healthcare is a series of complex systems and processes, and so for any new mechanism to be introduced, an organisation needs to go through a process of organisational development, even during a piloting or feasibility study.

There are two different paradigmatic approaches that explore how organisational development occurs. The first of these posits that organisations gradually develop over a sustained period of time, going through many incremental changes as is suggested within traditional evolutionary theories through mutations. However this paradigm has been described as being overly simplistic. The alternative to the traditionalist paradigm is the punctuated equilibrium paradigm, which argues that small changes occur during periods of stability which are then punctuated by revolutionary periods of change. Within these organisations, there are five fundamental or 'deep' structures which determine the overall

activity of the organisation; culture, strategy, structure, power distribution and control systems.

This resonates very closely with the organisational structure of the NHS, whereby periods of revolution are occurring with increased frequency. Moving away from PCTs towards CCGs can be argued to be a revolution in the deep structures of strategy, structure, power distribution and, with the creation of the NHS Commissioning Board and the removal of many arms-length bodies, a revolution in the control systems. The argument for a cultural shift is harder to provide. Instead, it can be argued that organisational cultures do not undergo the same process of change that other basic structures do, but require a more sustained period of development. For example the move towards a systems approach (and a culture of being open) within patient safety has been occurring for over a decade, and although it has achieved great success, it is still occurring. It is here that there is a distinction between practices, which can be controlled by top-down processes, and cultures, which are normally developed from the bottom-up.

The difference between incremental change and periods of revolution can play an important role within this study, particularly as a period of revolution cannot always be perceived prior to the event. At the outset of this study, the NHS was in a state of relative equilibrium or stability, with small changes occurring frequently with the intention of improving practice, which fits within the framework of the study of providing a small-scale change within the structure of patient reporting of safety.

However since the inception of the study, healthcare has gone through a period of revolution with the movement towards CCGs and the related changes in the deep structures within the NHS. These include the move away from targets towards an emphasis on individual responsibility and increased competition from the private sector which can have an unanticipated impact upon the processes of organisational development that occur during a period of stability. In particular it has been suggested that when organisations go through periods of revolution, small-scale organisational development projects can lose the prioritisation that they once had until the revolutionary period is over (Hayes, 2010).

The impact of the reforms to the study are evident in the difficulties that arose during the second cycle of piloting where the distribution rates of the reporting mechanism reduced significantly, and the quality of information on who the reporting mechanism had been distributed to also reduced. This mirrors similar findings by Fulop et al. (2002) who highlighted that when organisations merge together, managerial focus reduces and impacts

upon the delivery of services. They concluded that other healthcare organisations that are going through transformations should take the potential disruptions into account. The difficulties that arose during the development of the reporting mechanism in this study suggest that it does not only apply to operational aspects of an organisation but also developmental aspects as well.

Another important factor that may have influenced the overall distribution of the reporting mechanism is that of organisational culture. It has already been highlighted that having a safety orientated culture can improve incident reporting amongst healthcare professionals (Department of Health, 2000b; Reason, 1998, 2000; Reiman, Pietikainen, & Oedewald, 2010; Woodward, Lemer, & Wu, 2009), and this can also be extended to their involvement within this study. A healthcare organisation with a poor patient safety culture would likely not want to encourage the reporting of safety, regardless of who was providing the reports. Within this study, it is not believed that organisational cultures impacted upon the distribution rate of the reporting mechanism to service users. The healthcare professionals responsible for distributing the reporting mechanism had also been involved throughout each of the earlier stages of the research process and had many opportunities to either not participate in to begin with or to drop out of the study if they had a poor safety culture.

This does not mean that the culture of an organisation is not important in service user reporting of safety. Healthcare professionals were purposively sampled in this study based upon indicators of their organisations having a strong patient safety culture. Some organisations did not wish to participate once they were informed of the aims and objectives of the study. It is possible that this was due to a fear of retribution, given that the study was funded by the North East SHA. It is far less likely that organisations dropping out of the study did so due to their organisational culture, as they probably would not have participated in the first place if this was the case. Any future studies will still need to take into account organisational cultures when developing any reporting mechanism, regardless of if it is healthcare professional or service user reporting of safety.

Response Rates

Across both rounds of piloting the response rate from service users was 41.44%. The response rates reduced slightly from Cycle 1 (45%) to Cycle 2 (36%). The most likely explanation for this difference in response rates is a natural variance caused by the different numbers of reporting mechanisms that were distributed in each cycle of piloting; 91 in Cycle 1 and 61 in Cycle 2.

Regardless of the differences in response rates across both rounds of piloting, they were still of an acceptable level when considered in relation to the sample. McColl et al. (2001) found in an extensive literature review of surveys that non-respondents are more likely to be elderly people than younger people. This helps to explain why the expected response rate of between 55.6% (Baruch, 1999) to 67% (Sitzia & Wood, 1998) that has been identified to be standard within healthcare service surveys was not achieved in this study. Furthermore, the review of methods to obtain service user reports of safety by King et al. (2010) identified that self-initiated reports, where the onus was on the service user to report safety yielded lower responses than solicited reports, where service users were requested to answer questions. Although there was a degree of solicitation in this study, the onus was still on the service users to complete and return the reporting mechanism if they wished to do so, therefore potentially reducing the response rates in comparison to direct solicitation of service user reports of safety.

Sitzia and Wood (1998) highlight the impact that response rates have upon the generalisability of the findings, where results will be negligible if less satisfied service users do not respond. Although this may have been the case in this study where only people happy with the reporting mechanism responded (as can be summarised from the largely positive responses in the evaluation data), it was possible that this did not impact upon the patient reports of safety as incidence rates are similar to those reported by healthcare professionals in organisational care transfers (Tsilimingras & Bates, 2008). This suggests that service users were able to distinguish between being unsafe and being unhappy with the reporting mechanism. Future research or future piloting of the reporting mechanism needs to capture patient reports of safety from those that may have been unwilling or unable to complete the reporting mechanism to determine if there were any differences in reports on safety and to further improve the reporting mechanism so that it yields a higher response rate (and is therefore more representative).

Reports of Safety

The reports of safety provided by service users across the two rounds of piloting suggested that where service users were willing and able to respond, they could identify a number of different issues that impacted upon their safety, either positively or negatively. There are two ways in which to explore the data; either by reducing the organisational care transfer down into its individual stages (departure, journey and arrival) and classify each one as an episode of care, or to combine all three together to provide a single episode of care.

By exploring the stages of the organisational care transfer as individual episodes, it is possible to establish an incident rate for each stage so as to create a comparison between the three and to determine at which point of the transfer service users felt most unsafe. During the departure stage of their transfer, service users reported feeling unsafe 24 times. From these 24 reports, 12 were from discrete service users which gives an incident rate of 19.05%. During their journey, service users reported feeling unsafe 17 times. From these 17 reports, seven were from discrete service users which give an incident rate of 11.11%. During their arrival, service users reported feeling unsafe 27 times. From these 27, 11 were from discrete service users which give an incident rate of 17.46%.

These figures suggest that service users often felt the most unsafe during the admission and discharge processes of the organisational care transfer. These findings are similar to those reported elsewhere in the literature for organisational care transfers. For example Tsilimingras and Bates (2008) identified that one in five elderly people discharged from hospital suffered an adverse event, although the methods of the studies included in this review differed significantly to those used within this study as patient perceptions of safety were not measured. Despite this, the levels of incidents on both admission and discharge are similar to those identified using these methods. This suggests that service users in this study were able to identify a similar level of incidents as previous studies. However caution should be taken as Tsilimingras and Bates (2008) identified themselves that there were very few studies exploring the number of incidents post-discharge.

Service users reported feeling unsafe fewer times during the journey stage of the organisational care transfer. This was consistent across both rounds of piloting and when the two rounds were collated together. In order to explain this finding, it is necessary to refer back to the literature on where incidents are most likely to occur within a healthcare setting. It has already been identified that organisational care transfers, through the exploration of gaps in healthcare, are higher in risk than other areas of healthcare (Cook, Render, & Woods, 2000). This provides the explanation for the increased number of reports of unsafe care during the departure and arrival stages of the organisational care transfer. However it can be argued that the journey stage of the organisational care transfer is one single episode of healthcare where service users are not crossing any organisational or institutional boundaries. Therefore the 11.11% incident rate identified by service users within this study is of a similar level of incidents identified elsewhere within a single episode of care (Department of Health, 2000b; Kohn, Corrigan, & Donaldson, 2000; Mendes, et al., 2009; Soop, et al., 2009; Vincent, Neale, & Woloshynowych, 2001).

When the organisational care transfer is classed as a single episode of care, service users reported feeling unsafe 71 times. These 71 reports were made by 19 discrete service users, resulting in an incident rate of 30.16%. This rate is significantly higher than that reported elsewhere in the literature, where within organisational care transfers it has been reported that it is around 20%.

The difference in the two rates is potentially due to service users feeling unsafe in just one stage of the organisational care transfer and not the other stages. There are three alternative explanations for this outcome. Firstly, the variation may be a natural and expected change that was a result of the methods utilised within this study; a combination of the sample being predominantly elderly service users and the reliance of service user reports. As has been highlighted, incidents occur in around 20% of organisational care transfers (Tsilimingras & Bates, 2008), however the variance can be explained by a finding that incidents are more likely to occur in elderly people (Tsilimingras, Brummel-Smith, & Brooks, 2009) and that service users report more incidents than healthcare professionals via medical record review (Weissman, et al., 2008).

Secondly, service users may not identify the organisational care transfer being a single episode of care, and they potentially recognise that it constitutes different stages depending upon the organisation in which they are a part of, for example recognising that the ambulance service is a different entity to the nursing home, community care team or hospital. These two explanations can work in combination. The third and an alternative explanation is that these boundaries in the stages of the organisational care transfer were created by the reporting mechanism itself, and that they imposed artificial boundaries upon the service users in the reporting of their safety.

In addition to the reports provided by service users within the pre-designated components of safety that were identified during Phase 1, service users were also able to detail other experiences that impacted upon their safety via slightly different methods in each cycle of piloting. Despite having this option available to them, there were very few reported by service users. This suggests that there was a degree of saliency associated with the components of safety by service users, where they recognised that the components of safety included within the reporting mechanism had accurately captured what had made them feel safe or unsafe during the organisational care transfer. An alternative explanation is that it may have been an artefact of the reporting mechanism itself, where service users felt that they were unable to expand on their answers or were unsure of what had made them feel

safe or unsafe; a case of unknown unknowns. This needs to be taken into consideration as the lack of reports on other components of safety not identified within the sample of service users in this study does not indicate that safety can be easily reduced down into the six domains.

The findings can also be placed within the context of other studies exploring service user reporting of safety. As has already been identified, service users have been reported to identify more safety incidents than healthcare professionals (Weissman, et al., 2008). Burroughs et al. (2007) also found similar, where 39% of all respondents to telephone interview questions stated that they had experienced at least one concern around their safety, although 94% of respondents reported their safety as good, very good or excellent.

This resonates closely with how service users reported their overall safety within this study. Despite service users often reporting that they felt unsafe in one or more domains of safety, they still reported feeling safe overall for that stage of their organisational care transfer. However generally where people have reported feeling unsafe in one or more domains, there was a tendency to report that their overall safety was either neutral or unsafe. The lack of overall reports of feeling unsafe could be partially attributed to respondents that had felt unsafe not completing the overall question.

However where they have stated feeling safe despite reporting feeling unsafe in one or more domains, this could be representative of different levels of safety. For example the 'overall' feeling of safety, by only having three categories of 'safe', 'neutral' and 'unsafe' may be overly reductionist and therefore unable to capture the exact degrees to which people feel either safe or unsafe. Taking these implications further, it may be that each of the individual domains of safety contributes to varying degrees to a service user's overall feeling of safety. This would explain how service users who had felt unsafe in one or more domains of safety still felt safe overall.

This is potentially a limitation of the reporting mechanism in that it breaks overall safety down into ordinal data with too few categories to represent true feelings of safety. This can also be extended to each of the individual domains of safety, but was only evident in the discrepancies that arose in the reporting of overall safety. This potential limitation is discussed in greater depth in the limitations of the reporting mechanism section.

Based on the findings and that service users were able to identify when they had felt unsafe, it is possible that the reporting mechanism could be used to fill gaps in the reporting of safety

incidents. For example the North East Ambulance Service over a period of six months only reported five safety incidents (NPSA, 2011c). However it should be remembered that service users should not be relied upon to report on safety and overall responsibility should lie with the healthcare professional (Davis, et al., 2007).

These findings also have important theoretical implications, in particular when they are applied to the Swiss-Cheese model of safety (Reason, 2000). The theoretical implications of these findings are presented on pages 213-217.

8.2.3.3 Limitations of and Recommendations for the Reporting Mechanism

There are a number of limitations of both the reporting mechanism and the study as a whole. This section highlights the limitations of the reporting mechanism that were uncovered as a result of the piloting and also in reflection of the use of a survey to collect service user reports of their safety. The limitations focus specifically on the design of the reporting mechanism, the distribution and responses, the reports that were received and the ability of the reports to improve services and make them safer in the future.

The first of the limitations relates to the use of a survey to capture service user experiences of their safety. Although surveys as a whole have been the most popular option for capturing these experiences (King, et al., 2010), they may not be the most appropriate method for doing so. Within this study, one participant raised the concern that service users may become over encumbered with questionnaires and surveys about their experiences, which could potentially impact upon both the quality of responses if service users spent less time completing them, or even the total number of responses.

Another limitation of the reporting mechanism came about as a result of the processes of development, both during the workshops and modifications that were made following each cycle of piloting. These modifications, and to an extent the development of the reporting mechanism, were all based on service user requirements for the reporting mechanism. However this overlooked the requirements of each of the organisations that the reports were relating to. Consequently the reporting mechanism, although tailored to the needs of the service user, did not provide detailed enough information from which to improve services. For example it was not evident what lessons could be learned from the service user reports unless they had specifically expanded upon any point.

Despite this being a limitation of the reporting mechanism, it is not a limitation of the study itself as it was not within the study's original scope. Therefore any future development or implementation of the reporting mechanism should take into account the needs of the organisation in which they are being piloted and the systems that are available to them. One recommendation in order to capture more useful information from patients would be to include a section on the reporting mechanism requesting service users to expand upon their answers that are of most importance to them.

An alternative manner in which the reporting mechanism could be utilised would be to move away from the focus on individual reports, similar to experience surveys, as a means to improve services and instead focus on the collection of a larger sample of service users to highlight underlying safety trends via root cause analysis and address them in a systematic manner; much the same approach used by the NPSA in the analysis of healthcare professional reports of safety. However this would introduce and increase further limitations of the reporting mechanism. One such limitation would be that it is not able to measure the severity of an incident, as defined by the NPSA (2011a). According to the NPSA, patient safety incidents can result in 'no harm: impact prevented', 'no harm: impact not prevented', 'low harm', 'moderate harm', 'severe harm' and 'death'.

Any future development of the reporting mechanism needs to focus more specifically on what organisations require in order to improve their services, and one such way of doing this would be to categorise the service user reports of safety by severity. This should be coupled with capturing never events (detailed in Department of Health, 2011; National Patient Safety Agency, 2010a). Given that it has been identified that service users are unable to identify and report on technical errors (Solberg, et al., 2008), this could potentially provide service users with guidance in doing so. This is further supported by service users in Phase 1 identifying both technical and interpersonal aspects of care during the interviews which are two central components of quality healthcare (Donabedian, 1988). However care should be taken to avoid moving away from the patient-centeredness of the reporting mechanism by incorporating service user perceptions into this future development.

Also in relation to technical errors, a lack of communication, in particular documentation can result in a technical error, such as a misadministration of medication. This communication between healthcare professionals was not captured in the reporting mechanism, such as the accuracy and completeness of service user documentation on discharge and arrival. The same principle also applies to service users who are dependent upon their healthcare professional upon arrival into a care setting, such as when a service user is discharged from

hospital to a nursing home. If that service user requires the healthcare professional at the nursing home to provide them with medication, they may not become aware of any issues regarding their safety. In particular the private nursing home manager participating in this study indicated that the reports of safety were not as valuable as they could have been as the reporting mechanism was lacking in the ability to identify these technical errors.

Cwinn et al. (2009) have reported that information gaps occur in 85.5% of organisational care transfers that occur between nursing homes and the emergency department, which explains why the priorities of the nursing home were leaning heavily towards this aspect of the organisational care transfer. This highlights how healthcare professionals and service users interpret and perceive reality differently, even though both are of importance. The private nursing home manager stated that the piloting of the reporting mechanism was useful in terms of highlighting that patients cannot always report all incidents and so greater work needs to be done interprofessionally and interorganisationally to improve safety. Again this emphasises the need for the safety of service users to be the ultimate responsibility of their healthcare professional, and it does not indicate that service user reporting of safety is not worthwhile.

Furthermore based upon the feedback provided by service users during the evaluation of the reporting mechanism, few found it difficult to understand what was meant by the term 'your transfer'. This was a key discussion point during the development of the reporting mechanism and received much attention in the workshops, however based upon this feedback it may need to be rephrased in a manner which is more understandable to service users. It is possible that this was a larger problem than was reported during the evaluation as many service users did not complete the evaluation form or the reporting mechanism, with this lack of understanding possibly being a contributing factor.

8.3 Theoretical Discussion

Prior to discussing the theoretical implications of this research and its findings, it is important to reflect again upon the philosophical assumptions of the study and the author, so that the theory can be positioned within these. The relationship between ontology and epistemology is often confused within traditional realist or interpretive research, where ontological questions are often reduced to epistemological ones; a mistake referred to as the epistemic fallacy (Nairn, 2012). The critical realist approach within this study avoids this mistake by creating a clear distinction between epistemology and ontology. According to Bhaskar,

epistemology is the way in which access to knowledge of the world is gained, whilst ontology is what constitutes the world.

How safety is perceived by service users was addressed within Phase 1 of the study, exploring their perceptions and the terms that they used when discussing what had made them feel safe and unsafe when going through an organisational care transfer. This represented the transitive nature of reality, where these perceptions or interpretations differ between individuals or groups of people. The difference amongst individuals was reflected in this study in the different stories that service users told about their safety, which showed a degree of variance, which is expected amongst a small number of people who all experience different situations. Likewise, asking 14 healthcare professionals from three different organisations with a relatively limited amount of experience of organisational care transfers would potentially result in a similar degree of variance.

However the difference between groups was more apparent when these perceptions were aggregated, which resulted in a different definition of safety between service users in this study and healthcare professionals in the wider literature. These differences relate to the epistemological processes that occur when describing and making sense of the world, and so as not to fall into the epistemic fallacy, are distinct from the world itself. To further clarify, these differences are differences in how the world is perceived, not that different worlds are being perceived. These different interpretations are not classed as individual or multiple 'truths', but are instead equally valid perceptions of a single reality.

To reflect on where these findings fit within the philosophical framework, Phase 1 utilised qualitative methods to uncover the underlying truth behind safety, whilst Phase 2 through the utilisation of quantitative methods identified the patterns of practice, or frequency of this underlying truth (McEvoy & Richards, 2006). One particular facet of critical realism is that these can then be used to explore causal mechanisms; in this study the processes that impact upon a service users' safety.

To understand the importance of these findings in relation to the causal mechanisms (as defined by Bhaskar, 1978) of safety, it is necessary to explore ways in which they can be applied to current structures and processes within healthcare and how they impact upon patient outcomes (Donabedian, 1966). In particular there has been a recent call to apply theories more widely to patient safety practices (Foy, et al., 2011). One such model that the findings can be applied to is the Swiss-Cheese model of safety developed by Reason (2000). According to this model, patient safety incidents occur when holes in the barriers,

defences and safeguards (hereby referred to as safety buffers) line up and allow a hazard to pass through. It is for this reason that a number of different safety buffers are implemented into healthcare, so that when one fails, it does not necessarily directly impact upon the patients' safety as other safety buffers can stop the hazard.

Through the application of communication and responsiveness to the Swiss-Cheese model of safety (Figure 8.1), additional defences, barriers or safeguards can be constructed so as to reduce the chances of a hazard resulting in an adverse event. This can be achieved by healthcare professionals adhering to the individual elements of the communication and responsiveness themes, enabling them to provide safer care by involving the patient as an extra safety buffer (Davis, et al., 2007). When clinicians do not adhere to these safety acts, holes in the Swiss-Cheese may open up, allowing for a hazard to become an adverse event. It is therefore reasonable to support the call by Burroughs et al. (2007) to include communication within the traditional definition of safety, and to expand upon this to also include responsiveness.

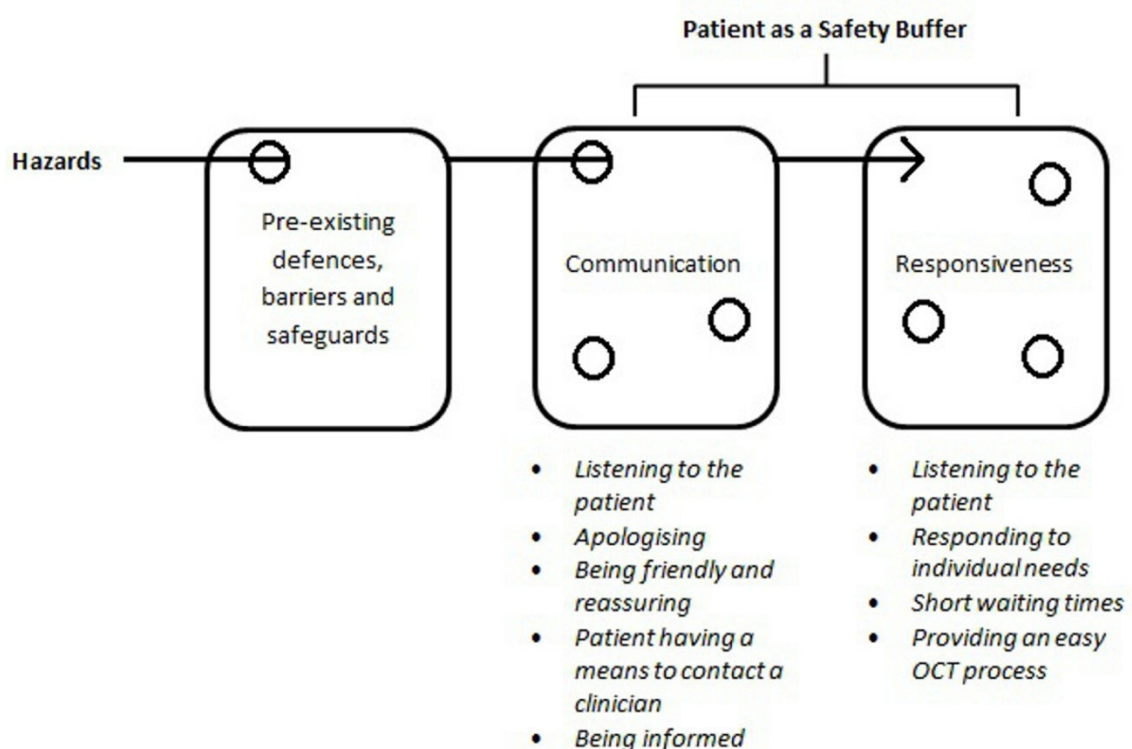


Figure 8.1: The role of communication and responsiveness in the Swiss-Cheese model of safety.

Within this modified Swiss-Cheese model of safety (Figure 8.1), communication with the patient and being responsive to patient needs have purposively been placed as the last two

safety buffers, although their order is not of importance. This represents the conclusion of Davis et al. (2007) who stated that patients should only be involved in their own safety when they are willing and able. As these safety buffers are not present in every situation and patient safety should ultimately be the responsibility of healthcare professionals, it is reasonable that they operate as a final safety buffer, rather than as a first. The pre-existing defences, barriers and safeguards constitute many other aspects of care that make up the organisational care transfer which aim to reduce the number of traditional safety issues that are already known about. For example there are many procedures in place to reduce the number of falls and medication safety issues that exist within organisational care transfers.

A key component of the Swiss-Cheese model of safety is that the reporting of safety is necessary in order to identify where holes in layers of the Swiss-Cheese open up, along with identifying resident pathogens already in existence within the system (Reason, 2000). The reporting mechanism developed in this study fulfils this role, allowing service users to report on their safety when going through an organisational care transfer and therefore identifying where these holes and resident pathogens exist. Through the use of critical realism within this study and the notion that different groups hold different interpretations of reality, there is consequently a need for service users to be able to report on these safety issues as healthcare professionals, due to their roles within healthcare services, are unable to identify and report.

The findings also have theoretical implications for the recent International Classification of Patient Safety (ICPS) conceptual framework (Sherman, et al., 2009), which uses the Swiss-Cheese model of safety (Reason, 2000) and Donabedian's (1966, 1988, 2003) model of quality as foundations. Therefore any additions to the Swiss-Cheese model of safety also impacts upon the ICPS. As they share many of the same characteristics, the modification is only minor through expanding the detection of incidents to include service user reports in addition to healthcare professional reports.

Caution should be taken when considering a modification to the Swiss-Cheese model of safety. Perneger (2005) identified that interpretations of the model differ amongst healthcare professionals, although the author correctly recognises that there are limitations in the methodology; namely that the sample was self-selecting and unrepresentative of healthcare professionals working in the field of quality and safety. A more likely rationale for the findings is that interpretations differ due to different levels of knowledge amongst healthcare professionals, of which improved awareness of the model and the expansion of the model proposed from the findings of this study would alleviate.

Of course by utilising a critical realist philosophical approach, the transitive dimension of reality is often likely to fluctuate and differ depending upon contextual and time factors. Therefore any such conclusions in relation to theory drawn in this section need to be explored within other healthcare settings and across time. This is particularly evident within the field of patient safety which is forever changing as healthcare modernises and the structures of healthcare, such as the manner in which the NHS is constructed, are forever changing. Similar conclusions have also been reached when developing the International Classification for Patient Safety (Sherman, et al., 2009)

The involvement of service users in reporting their safety also has implications for patient and public involvement. According to Arnstein's ladder of involvement (Arnstein, 1969) there are eight different levels of patient and public involvement with three overarching categories; nonparticipation, tokenism and citizen power. Within this study, service users fell within the citizen power category, mostly under the term of partnership where they had an equal voice to healthcare professionals when developing the reporting mechanism. This is a key component of AR which is said to be emancipatory in the processes it utilises by giving power to participants, or co-researchers to influence their own course of actions (Stringer, 2007). This was further strengthened through utilising service user perceptions of safety to underpin the reporting mechanism.

The reporting of safety sits on a lower rung of the ladder than the methods used to develop it within this study. It can be positioned within the tokenism category, or more specifically consultation. The negative connotations that can be associated with tokenism do not necessarily apply here. Any greater levels of participation may not be possible within the reporting of safety, especially when not all service users are willing or able to be involved in their safety. As Davis et al. (2007) identified there are five factors that may influence involvement in safety; patient-related, illness-related, healthcare professional-related, healthcare setting-related and task-related. The reporting mechanism developed in this study reduces the chances of healthcare professional-related factors, such as blame cultures, negatively impacting upon the service user involvement in their safety. It does this by bypassing individual knowledge and beliefs of healthcare professionals that may otherwise be a barrier to involving the service user.

8.4 Implications for Policy and Practice

There are a number of implications for both practice and policy. As both practice and policy are interlinked, it is not always possible to split the implications, and as such they are reported together in this section.

8.4.1 Broader Definition of Safety

The first of the implications of the findings relate to Phase 1; the service user definitions of safety within organisational care transfers. The finding that service users perceive safety differently suggests that current working definitions of safety need to incorporate the service user perspective. This implication is supportive of the current focus on patient-reported outcomes, where an emphasis is placed upon what service users feel is important; in this study this included communication and responsiveness as being important to them feeling safe alongside traditional safety issues.

8.4.2 Requirement for Service User Reports of Safety

The findings that some service users were both willing and able to report on their safety has many implications for practice and policy, both locally and nationally. Given the emphasis placed upon patient-reported outcomes in current healthcare policy, the collection of service user reports on their safety is a viable method of organisational learning and capturing the patient experience of safety. These reports are able to be used in conjunction with healthcare professional reports in order to highlight any safety trends across both the service user- and healthcare professional-perceived domains of safety. The need for this is further supported when it is considered that patients are aware of changing trends in healthcare, such as the move away from hospital-based care to community care (Kielmann, et al., 2011). According to Keilmann et al. safety is one of the most important factors in supporting this move, suggesting that service users are becoming more aware that safety is of importance, even in relation to organisational care transfers.

By classifying these service user reports of safety as experience reports, the boundary between reporting safety and reporting satisfaction is further blurred. Rathert, May and Williams (2011) reported that safety perceptions may influence satisfaction, therefore any measures and subsequent improvements made to reduce negative reports of safety perceptions may have a positive impact upon an organisation's overall satisfaction scores. This has particular implications for policy and practice when considered in relation to the objectives of the current government; "the service must be focused on outcomes and the

quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all." (Department of Health, 2010a, p. 4).

Given the link between patient perceptions of safety and satisfaction (Burroughs, et al., 2005; Kuzel, et al., 2004; Rathert, May, & Williams, 2011), there is a strong argument that it would be beneficial for organisations to measure patient perceptions of safety, resulting in both improved safety and satisfaction by acting as an incentive for change (Longo, et al., 1997; Riiskjær, et al., 2010). Furthermore, it is believed that the active measurement of service user experiences is a key facilitator for improving how patient-centred care is (Luxford, Safran, & Delbanco, 2011).

Furthermore there have already been a number of pieces of research that have identified that where service users are to be involved in their safety there should not be a reliance placed upon them. Instead final responsibility should lie with their healthcare professional (Davis, et al., 2007). It is therefore important to highlight that the patient reporting of safety should not replace any other form of incident detection, and the service user should be used as a last line of defence. This is particularly relevant as some service users are unwilling or unable to report on their safety (Davis, et al., 2007).

Despite some service users being unwilling or unable to report on their safety, it is still beneficial to capture reports from those that are. Naessens et al. (2009) identified that multiple methods of detection elicited different adverse events. In addition to this, the finding from this study that service user definitions of safety differ to healthcare professional definitions, suggests that they are the only ones able to identify and report on those aspects of their safety.

8.4.3 Implementing Service User Reports of Safety

Looking towards the future and how the reporting mechanism could be introduced into organisations, there are two different approaches that could be taken. The first relies upon individual healthcare professionals to identify the need for the patient reporting, and to implement the reporting mechanism based upon a self-desire for improving service quality. This method has a number of limitations in that healthcare professionals often have very limited time and resources available to them, and so by concentrating on the reporting mechanism would have implications for practice elsewhere. Furthermore, the resources

required to collate and react to safety reports by service users are not available to individual healthcare professionals or even teams.

The second approach resolves these issues by taking a top-down, policy driven approach to the implementation of the reporting mechanism. High Quality Care for All (Department of Health, 2008a) introduced the need for an incentive for increased innovation that would improve healthcare quality. The Commissioning for Quality and Innovation (CQUIN) payment framework (Department of Health, 2008b) [also include 09/10 operating framework reference] provided this incentive for Acute Trusts, where contracts link payment to quality improvement. This was later revised to include community, mental health and ambulance services (Department of Health, 2010f). Although changes are currently underway with regards to how services are commissioned and by whom, the CQUIN payment framework will remain for the foreseeable future, and has actually been increased from 0.5% of provider contract value to 1.5% (Department of Health, 2010f), representing the emphasis that is placed upon improving quality via innovation.

It is possible that the use of a CQUIN scheme, which “should address the three domains of quality: safety, effectiveness and patient experience; and reflect innovation” (Department of Health, 2010f), would provide the ideal opportunity for a policy-driven implementation of the reporting mechanism, where the relevant organisations (acute trusts and community services) are incentivised to collect patient reports of safety.

8.4.4 Private and Social Care Homes

Although the CQUIN provides an opportunity for NHS Trusts to receive funding for innovative services, there are no such incentives available in private and social care homes of which I am aware. If there are any such opportunities, both commissioners of these services and providers should implement the reporting mechanism to capture service user experiences of their safety, taking into consideration the particular population groups within these settings, which would produce the same learning outcomes as within NHS settings.

Where incentives are not available, then the Care Quality Commission would be in a position to implement punitive measures for organisations not capturing the service user experience. However this is not recommended as it does not foster a safety culture as some features of punitive processes are synonymous with the blame culture of safety. An alternative would instead be to consider that the majority of organisational care transfers within private care

homes are to and from hospitals, where the transfer would be captured by the CQUIN funded organisations. This would also serve to avoid repetition for service users.

8.4.5 The Need for Collaborative Working

Organisational care transfers have already been identified to be particularly high in risk when service users cross organisational and professional boundaries (Cook, Render, & Woods, 2000). There has been a large amount of research highlighting the need for better communication between healthcare professionals to increase safety (Arora, et al., 2008; Helleso, Lorensen, & Sorensen, 2004; Kripalani, et al., 2007; Vieira & Kumar, 2009).

This is of even greater importance in the context of service user reporting of safety during organisational care transfers as the process of learning from the reports differs greatly. Healthcare professional reports are returned to the NPSA to be analysed for trends, from which root cause analysis is used to determine the origins of the incident. With reports collected from the service user reporting mechanism, they are returned to the organisation from which they were distributed. As they capture the departure, journey and arrival, this potentially represents three different organisations that are being reported about. There is therefore a larger requirement for collaborative working across the different organisations than with healthcare professional reports in order to share the information and subsequently the lessons learned to improve safety.

8.5 Recommendations

8.5.1 Implementing the Reporting Mechanism

Based on the findings from the two rounds of piloting it is possible to establish recommendations for the future development of the reporting mechanism, whether that be piloting or the eventual implementation into organisations. These recommendations are based solely on the findings from the two rounds of piloting. The current processes and frameworks already in existence for how the reporting mechanism could be implemented into organisations have been discussed in the previous section (8.5).

Based upon the two rounds of piloting, response rates were higher when the reporting mechanism was distributed to service users entering, rather than departing the service. Although both yielded satisfactory levels of responses, any future implementation or piloting should distribute the reporting mechanism to service users when departing from the service so that greater responses are achieved and there is more data with which to analyse, thus

being in a stronger position to identify any safety trends. Where this is not possible, for example when a service user is discharged home from hospital, the reporting mechanism should be distributed on departure. Another method of improving response rates would be to directly solicit responses from service users (King, et al., 2010), with a coherent strategy of distributing and inviting service users to complete the reporting mechanism in the same manner as other service user questionnaires (e.g. McColl, et al., 2001).

A further finding from piloting the reporting mechanism was that the majority of service users that responded were supportive of the reporting mechanism. However it is unknown if this was a result of bias where only those happy with the reporting mechanism responded. Future piloting and implementation should include a more in-depth evaluation of the reporting mechanism where service users that do not want to complete the reporting mechanism are purposively sampled to explore the reasons why. Given a larger sample size it will also be possible to statistically determine service user characteristics that impact upon both responding to the reporting mechanism and the reports that they provide.

The reporting mechanism was developed and piloted with elderly people going through an organisational care transfer into and out of NHS community care teams, social care homes and private nursing homes within the North East of England. Feasibility studies will be required to determine if it is transferable to other settings with different population groups, such as young people. Similarly as healthcare is constantly changing (Sherman, et al., 2009), there should also be an ongoing evaluation of service user perceptions of safety to determine if they change, particularly as healthcare moves towards a more community-based model.

Consideration for people with sight difficulties should be made, such as colour blindness or the size of the text, especially when being given to elderly people who may have sight difficulties. A similar recommendation is that other languages should be available as all respondents within this study were White British, with the exception of one Irish person. It is presumed that their first language was English.

A stronger process of learning from the service user reports should also be implemented into the organisations. For safe care, this should be a positive feedback loop for healthcare professionals. For unsafe care, this can be used to learn from the incidents, identifying any potential hazards that could lead to a patient safety incident.

The mechanism should also be tailored to the individual care settings in which it is being piloted or implemented in. One finding was that some service users, when being discharged home from hospital did not have adequate community support in place. The reporting mechanism should try to capture this in community care teams.

8.5.2 Future Research

In addition to further development of the reporting mechanism, there are also a number of other areas in which the research could be further developed in the future. The first of these is to explore perspectives of safe care from a range of other service users either in similar or different healthcare settings. The reason for this is that it may be possible that perceptions of safety differ across population groups, for example children may discuss other components of their care as being important to making them feel safe. Future research should also explore other service user demographics, such as gender, socio-economic status, ethnicity and geographic location.

A more in-depth exploration of patient perceptions of safety is needed. Although those presented within this study represented how these participants perceived safety, it is currently unknown if definitions of safety differ by different populations, although the limited amount of research suggests that it is. For example Burroughs et al. (2007), when exploring perceptions of safety within an emergency department found distinctly different perceptions in comparison to this study. This reflects the differences in safety concerns from different healthcare settings. It would therefore be viable for an exploration of how patient perceptions of safety differ across healthcare settings, along with other variables such as gender, age and ethnicity of service users. Given that healthcare professionals, and consequently patient satisfaction, have been reported to impact upon perceptions of safety (Rathert, May, & Williams, 2011), it would also be viable to explore how other variables such as healthcare experience impact upon these.

Finally, it is viable to explore both service user perceptions and reports of safety of service users who are independent in comparison to those who are dependent on the care that they receive. There may be differences between these two groups depending upon the reliance they place upon healthcare professionals, thus potentially perceiving the care and subsequently their safety differently to those with less reliance on their healthcare. It would be possible to build on the findings of this study that trust had a relationship with perceptions of and potentially the reporting of safety. This would be able to explore the combined relationship between dependence on healthcare services and trust.

8.6 Limitations of the Study

8.6.1 Limitations of the Methodology

By using AI, a form of AR itself, within a wider Participatory AR study introduced some methodological conflicts. The first of these is that AI predominantly explores what works well within an organisation, with the intention of building upon these factors. Although this has been shown to work within some settings, it has its limitations within a patient safety setting that traditionally focuses on what has gone wrong, although paradoxically this is also a major strength of the study. The major limitation is that it does not currently fit with theories of safety. For example the Swiss-Cheese model of safety (Reason, 2000) focuses specifically on hazards and ways in which hazards can be stopped before they become a patient safety incident. This therefore required a slight modification to the model, where safe care constitutes the barriers, safeguards and defences (safety buffers) to stop these hazards. The methodological limitation of this is that there is an assumption that what constitutes safe care, the opposite constitutes unsafe care.

Although this appears to be an acceptable explanation, further work is required to determine if they sit as polar opposites on a continuum where equal weighting is placed upon each of the components of the modified Swiss-Cheese model of safety proposed in this study where the service user can act as an additional safety buffer. Similarly on a more fundamental level, the use of AI during interviews with service users to explore their experiences of safe care during organisational care transfers may have concealed other issues they may have considered pertinent to their safety. Although some service users broke away from the focus on safe care to speak of negative experiences, others may not have done so.

An additional methodological limitation relates to the collaborative nature of AR, where healthcare professionals from various settings were working together with service users in the development of the reporting mechanism. Although collaborative working can be a process of active construction by the researcher in developing interorganisational learning (Huzzard, Ahlberg, & Ekman, 2010), this may not have happened as efficiently as it could have within this study. Firstly, the number of organisations involved in this study was considerably smaller than Huzzard et al. (2010), and secondly, those organisations that were involved in the study do not usually work together; i.e. patient transfers do not usually occur between those involved, and so there was no opportunity for them to collaborate to improve practice or to reflect upon the transfer processes. Involvement of teams that actively discharge and admit patients to the social care homes, community care teams and private

nursing homes that were involved in this study would have increased the interorganisational learning, so that they could each understand the processes of the other.

8.6.2 Limitations of the Sample

There were a number of limitations of the study relating to the sample selected in each phase of the study. During Phase 1, service users were all elderly from a small number of organisations within one region of the country. It may be possible that other service user characteristics may impact upon perceptions of safety in a similar manner that they impact upon involvement in safety (Davis, et al., 2007). Other characteristics may have included different age groups, care settings, medical conditions, ethnicities or socio-economic statuses.

Furthermore there are a number of limitations in relation to the sampling methods used. Due to the researcher being unable to access service user details, healthcare professionals were asked to identify and approach service users on the researcher's behalf. In most cases, this has the potential to introduce considerable bias into the study where healthcare professionals may only approach those service users that had positive experiences to tell. However the use of AI within this study, focusing on what had made service users feel safe, helped to lessen the impact of any such bias. Despite this, it is still possible that unintentional bias was introduced in other ways, such as only choosing service users who liked to talk the most, thus excluding more quiet service users.

There were also a number of limitations in relation to the development of the reporting mechanism. The most apparent of these was that no service users from Phase 1 contributed to the development of the reporting mechanism, with the exception of providing their experiences of safety in Phase 1 which informed the domains of safety within it. It would have been beneficial to have their input into the development of the reporting mechanism along with the expert patients so that the links between the two phases were not solely artificially created by the researcher via a presentation at the start of each workshop.

Finally there were also limitations to the sample when piloting the reporting mechanism, although these mirror many of the same limitations as identified in Phase 1. Again respondents were elderly service users who were predominantly White British, with one person who was Irish. Full details on medical conditions were not available, likewise there was also data missing for where they had transferred to and from. The reporting mechanism was also only piloted within a small number of organisations. It is likely that the processes

involved in transferring service users change between individual organisations, in particular private nursing and social care homes where there are less likely to be standardised procedures than in the NHS due to different prioritisations.

Healthcare professionals were also responsible for identifying and distributing the reporting mechanism to service users, which had the potential to introduce bias. Unlike Phase 1 where the AI methodology was used to limit the impact of any such bias, this would not have been as apparent within the piloting of the reporting mechanism. Despite this potential bias, there were still a large number of reports of feeling unsafe. Bias may have also been introduced in the evaluation of the reporting mechanism by the use of a self-selecting sample of respondents to evaluate the reporting mechanism. It is possible that only those who liked and understood the purpose of it proceeded to respond to it, thus providing a type I error, or a false positive. It was originally hoped that participants who did not want to complete the mechanism would have sent back an evaluation form saying why, but nobody did this.

Furthermore in relation to the evaluation, a very limited number of service users (two in Cycle 1, none in Cycle 2) volunteered to participate in an interview. Those that did provided very useful feedback that would otherwise have been unavailable using the evaluation form provided with each reporting mechanism. More service user interviews would have strengthened the evaluation of the reporting mechanism and potentially highlighted issues that would limit response rates.

8.6.3 Limitations of the Methods

The limitations of the methods used in this study particularly relate to the development and piloting of the reporting mechanism. During the development of the reporting mechanism through the two workshops, there was an apparent lack of direction given to participants as to what the expected outcomes were and that the reporting mechanism needed to focus on safety and not satisfaction. Also by placing expert patients alongside healthcare professionals, individual agendas may have impacted upon both groups of people and their willingness and focus on the tasks in the workshops. For example one expert patient in workshop 1 often attempted to tell their story of a poor experience apparently in an attempt to receive an answer as to why it may have happened.

Alternatively, healthcare professionals may have been overly defensive about their practices in an attempt to appear competent (not that being open would make them appear any other

way). Although it may have been more beneficial to split healthcare professionals and service users, this would actually have been a weakness of the study as there would not have been opportunity for collaboration and co-construction of the reporting mechanism taking into account both groups' perspectives and experiences.

With regards to both service user perceptions of safety in Phase 1 and also service user reports of safety in Phase 2, it would have been beneficial to compare these findings with other methods of incident identification, such as healthcare professional reports or a case note review. By doing this, a more detailed analysis of the meaning of the findings could have been given whilst not detracting from the importance of individual interpretations of reality identified as being necessary in the underlying philosophy of the study. Instead they could have provided a comparison to determine the extent to which perceptions and interpretations differ, rather than seeking to determine if the differences were due to different 'truths'. However due to both time and resource constraints it was not possible to do this; in particular as the researcher was not qualified to conduct case note reviews and healthcare professional reporting during organisational care transfers has been identified to be very limited.

Furthermore as has already been highlighted, it was not possible to explore the direct impact that the reporting mechanism had upon practice. As a feasibility, or piloting study this has suggested that service users can be and are willing to report on their safety, but further work is required on how these patient reports can be built into systems in order to improve practice. A discussion on the use of the CQUIN framework (Department of Health, 2008b, 2010f) is provided in section 8.5.

8.7 Contributions to Knowledge

This study provides original contributions to knowledge on three levels: conceptual, practical and methodological. At the conceptual level, patient perceptions of safety when going through an organisational care transfer are presented and applied to the Swiss-Cheese model of safety. Patient perceptions of safety, in particular communication and responsiveness, formed additional barriers, defences and safeguards. The reporting mechanism developed thus allowed patients to report on any holes in these safety barriers that may have impacted upon their safety, which offers a new practical solution to patient reporting of safety during organisational care transfers. The applicability of the patient perceptions of safety to the Swiss-Cheese model of safety have since been published (Scott, Dawson, & Jones, 2011, Appendix 15).

The use of Appreciative Inquiry offers a unique methodological contribution to knowledge by approaching patient safety research from a positive stance, which helps to reduce cultural and personal barriers often associated with researching safety, where patients may be unwilling to be critical of their healthcare. The novel combination of Appreciative Inquiry and Action Research adds to the methodological contribution through the process of development and piloting of the reporting mechanism, which provided an opportunity for healthcare professionals and service users to contribute equally, whilst ensuring it was still based upon service user perceptions of safety.

8.8 Conclusion

Service users perceived safety differently to healthcare professionals within organisational care transfers, including communication and responsiveness alongside other traditional safety issues in the definition of safety. These proposed domains of safety formed additional safety buffers within the Swiss-Cheese model of safety (Scott, Dawson, & Jones, 2011), which in turn would require service users to report on their own safety to identify where any active or latent failures may arise within the system.

The reporting mechanism developed in this study performed this function, with service users reporting on their own safety during their organisational care transfer, and with incident rates similar, or in some cases higher to those that would be expected using other means of incident identification. However the political landscape of these findings needs to be taken into consideration, in particular how policy changes may affect any future work that builds upon these findings.

At the time of conducting and writing this thesis, large political changes are occurring. The first coalition government since 1940 is in power, with a Conservative majority and Liberal minority. This is unique in itself, as two opposing political parties, with contrasting policies and political ideologies are trying to work together. Although the election occurred prior to data collection, the resultant impacts of a Conservative-led coalition on health and social care were evident in both policy and the resulting impact upon this study. At the point of writing, the full impact of the new policies is not fully clear, for example a final version of the Health and Social Care Bill is yet to be fully passed through the House of Lords. From this point forward, the coalition government shall be referred to solely as the Coalition.

Undoubtedly the largest change to health and social care is the restructuring of the NHS, where PCTs are to be abolished in favour of CCGs. An overview of the proposed changes to

health and social care is provided on page 26, though the most important point to reflect upon is that the White Paper, *Liberating the NHS* (Department of Health, 2010a), proposed large reforms to the structure of the NHS. This section of the thesis aims to discuss the wider implications of any such changes to the structure of the NHS on future studies, and in particular the future development of the reporting mechanism within a similar political and developmental climate.

It was coincidental that the two rounds of piloting the reporting mechanism fell on either side of the reforms. Round 1 was conducted prior to the release of the White Paper 'Liberating the NHS' (Department of Health, 2010a), whilst Round 2 was conducted after the publication of the White Paper. One of the outcomes from piloting the reporting mechanism was the disparity between the two rounds of piloting. There are a number of potential explanations for this outcome, however the two most apparent relate to theories and concepts of organisational development, which are also intertwined with policy development and by virtue of association, politics. These are Punctuated Equilibrium Theory (PET) and Path Dependency (PD), which have been described in the discussion.

PET focuses on the actual changes that occur to systems and organisations when policy is posited upon them, reflecting upon the impact of such changes. In particular it stipulates that organisations develop through small changes that happen during periods of stability which are then punctuated by larger, revolutionary periods of change. PD positions itself in a similar manner, although instead of focusing on how organisations develop as a means of agents' actions within the system, it focuses on the historical pathways and impacts of policy in a deterministic manner, which is neither dependent nor independent of PET, but instead occurs alongside of it. According to PD, once an organisation (or institution) begins to travel down one path, it becomes more difficult to move away from that path despite diminishing returns. I propose that these two different factors impact this study in relation to the research outcomes, and also the political context in which any future research based upon these findings will operate.

Over the coming months and years the structure of the NHS will change drastically, placing a large emphasis of commissioning onto GPs within the CCGs, where they are able to outsource the commissioning of healthcare services to private companies. This move is coupled with the proposed change in law that no longer requires the Secretary of State to provide a healthcare service, but rather to secure its provision. These jointly move the NHS further down the path of privatisation, and with the removal of senior NHS managers, the 'NHS brand' may be an unanticipated casualty of the reforms (Macfarlane, et al., 2011).

Tracing the steps of this path, it is arguable that the NHS was placed on this path a long time ago, with Margaret Thatcher implementing the internal market reforms which have been acknowledged to make privatisation simpler (Timmins, 1995). Following these reforms, successive governments have continued along the same path with an increasing emphasis on the marketisation of the NHS. There are arguments as to how such reforms will impact upon healthcare, and in particular in relation to this study; patient safety. One argument is that increased competition will drive up the quality of services and improve patient's safety, whilst the other argument is that there is limited emphasis placed upon quality and safety unless there is a direct and measurable financial return. Both of these result in the same outcome; an increased focus on measuring the returns gained by the NHS, of which Thatcher has been identified as being the potential instigator (Ross, 2007).

Regardless of whichever these may be true, there is an opportunity for patient involvement in patient safety, through patients reporting their experiences of safety, to be pushed to the forefront of both commissioners' and healthcare providers' agendas, and rather than seeing these changes as an obstacle that needs to be hurdled, they can be seen as an opportunity. This primarily comes in the form of changes to the deep structures, as theorised within PET. As the deep structures of the NHS, in particular the strategy, structure, power distribution and control systems change, there is scope to somewhat influence these and position any future research within the new systems that emerge. Indeed, it can be argued that the reporting mechanism itself both influences these, via existing systems, and modifies them through the potential creation of a new system in order to better achieve the transformed goals of the NHS.

These opportunities come from a number of policy documents and frameworks, including the NHS Outcomes Framework 2011/12 (Department of Health, 2010d), the NHS Operating Framework 2011/12 (Department of Health, 2010e), Equity and Excellence: Liberating the NHS White Paper (Department of Health, 2010a), the NHS Future Forum recommendations to Government (NHS Future Forum, 2011) and the CQUIN frameworks (Department of Health, 2008b, 2010f).

More specifically, two domains of the NHS Outcomes Framework 2011/12 (Department of Health, 2010d) are entitled 'Ensuring that people have a positive experience of care' and 'Treating and caring for people in a safe environment'. The NHS Operating Framework 2011/12 (Department of Health, 2010e, p. 9) highlights service quality, of which 'ensuring that the voice of patients [...] remains heard at all times' is a key component. Equity and

Excellence: Liberating the NHS (Department of Health, 2010a, p. 13) places an emphasis on outcomes that are of importance to service users, stating '[healthcare systems] have barely started to realise the potential of patients as joint providers of their own care', in particular saying that patient-reported outcomes and patient experience data will be central to an information revolution, allowing patients to rate services based on the quality of care they receive.

In order to achieve these, it should be possible to incorporate the reporting mechanism into CQUIN funding schemes, which commissions quality improvement work that must include at least one area of improvement in four domains; safety, effectiveness (including patient-reported outcomes), user experience and innovation (Department of Health, 2008b). The reporting mechanism developed in this study allows for each of these to be achieved by trying to improve safety through patient-reporting of experience via an innovative method. Further to these, the reporting mechanism, through its development within organisational care transfers and subsequent interorganisational links, helps to realise the potential for 'integrated care for patients and communities designed around their needs', as identified by the NHS Future Forum (2011, p. 26).

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Appendices

Appendix 1

Phase 1 – Service User Invitation Letter



SURE CARE

[A Research Study]

Invitation letter to service users (P1)

Dear Service User,

You are invited to take part in this research study

We are doing some research on your safety when going through a transfer in your care. It is a major study funded by the NHS North East Strategic Health Authority and Northumbria University.

What will this study do?

It will look at what makes you feel safe when you are going through a transfer in your care. The aim of the study is to inform and improve practice on both a local and national level.

How could you take part?

If you are interested in taking part we will ask you about times when you have felt safe and what makes you feel safe. To take part, you will be invited to have an informal interview with a researcher, which can be anywhere that you feel comfortable. If you need support to join in, you can choose to bring someone with you.

What to do if you are interested in taking part and want more information?

If you would like to find out more information about the SURE CARE study, please take the time to read the **Information Sheet** included with this letter. This will give you more information about the study. You may also contact the researchers directly to find out more information or to ask questions. The contact details of Jason Scott are at the end of this letter and in the information sheet.

Please turn over



We would also like family members, carers and advocates to be involved in this study. The Information Sheet tells you how they can get involved.

If you have decided you do not want to take part in the study, you do not need to do anything.

Thank you for taking the time to read this letter.

Contact Details


If you have any questions, please contact:

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 2

Phase 1 - Service User Information Sheet



SURE CARE

[A Research Study]

Information Sheet for service users (P1)

Part 1

We would like to invite you to join in this research project. Before you decide if you want to take part you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and talk to others about the study if you wish.

If you have any difficulties, or need other help to understand the information please contact us. Your participation could make a real difference to the quality of care provided, but take time to decide whether or not you would like to participate.

Below is a list of terms used in this document.

<i>Care transfer:</i>	This is when your care is passed from one service to another. Examples of this include being discharged from hospital or moving from one hospital to another.
<i>Service user:</i>	This is any person who comes into contact with the National Health Service (NHS). This includes patients, carers, family members and advocates.
<i>Adverse event:</i>	This is an incident or circumstance that could have or did lead to unintended or unexpected harm, loss or damage.
<i>Expert Patients:</i>	Expert patients have a high level of knowledge about health services. This is developed through personal experiences.



What is the purpose of the SURE CARE study?

At the moment there has been very little research looking at how service users perceive their safety when going through a care transfer. We want to look at what safe care feels like to service users going through a care transfer. We will then use this information to develop a tool to help service users to identify and report adverse events and times that went well when undergoing a care transfer. We want to hear from patients, family members, carers and advocates about times that they felt safe when going through a care transfer.

Why have I been invited to take part in SURE CARE?

You have been invited to take part as you have experience of going through a transfer in your care. We are very interested in hearing about your experience and how it affected your personal safety during your transfer.

Do I have to take part?

No, it is completely up to you to decide. We will explain the study to you in this Information Sheet. If you would like to take part based on the information provided, we will then ask you to sign the reply slip at the end of this Information Sheet to show you have agreed for a member of the research team to contact you to arrange an interview at a time and place convenient to you.

If you decide to take part and then change your mind, you can withdraw without giving a reason. You can do this at any time during the process of your involvement.

If you decide not to take part, or change your mind at any time it will not affect the standard of care you receive.

What will happen to me if I take part?

If you do decide to take part in the study, you will be asked to fill out the reply slip at the end of this Information Sheet. A researcher (Jason Scott) will then contact you to find out where and when you would like to be interviewed, and if you would like a carer, family member or advocate present. You will also be



asked your age, gender, ethnicity, and if you have any disabilities or other requirements. This is to help us to know if we are speaking to a wide variety of people and to accommodate for any needs you may have. The information will not be linked back to you as an individual, but you don't have to answer any of the questions if you do not want to. Before the interview, Jason Scott will explain the study to you in person and answer any questions you may have. He will then ask for your consent for the interview to begin.

The interview will last approximately one hour and you will be asked questions about your experiences when undergoing a transfer in your care, and to think about what would make you feel safe in future care transfers. The interview will be recorded using a digital voice recorder.

After the interview, the researcher will summarise what has been said and check with you to ensure that it is accurate. At a later date, you will also be provided with a summary of the findings, and you can request a full copy of the report if you want.

As this is the first part of a larger project, you may also be approached about participating in the second part. You do not have to do this if you want, and you will not be pressured into doing so. You will be provided with detailed information at the time, or if you would like more information in the meantime, please contact Jason Scott.

Will taking part cost me anything?

At no time will you be asked for any money or your bank details. Any money you spend on travel will be reimbursed.

How might taking part affect me?

This study will not involve any physical risks, but talking about your experiences might be upsetting or tiring. You can stop or have a break during an interview at any time. You will not be left alone until you tell us otherwise.

You will also be able to speak to another member of the research team in person or over the telephone if you wish.



If you get tired easily and need regular rests please let us know.

Will taking part in the project be private and confidential?

We will follow ethical and legal practice and all personal information about you will be handled in complete confidence. Anything that you say will be assigned a number that cannot be traced back to you personally. Direct quotes may be used, but you will not be identifiable through them.

When you speak to a researcher it will be recorded using a digital voice recorder. If you would not like to be recorded for any reason, you may request that the researcher take notes on the interview instead.

Some of the information that you give us will be used for an educational project, as one of the researchers (Jason Scott) is doing a PhD. This will also be treated confidentially.

All information will be stored on a secure computer within Northumbria University, and will only be accessible by Jason Scott, the Chief Investigator. All personal information will be destroyed when the study ends, and any written and recorded information will be destroyed six years after the study ends.

Breaking confidentiality

If you tell us something during the study that suggests you, or someone else, are at serious risk, we would then have to break confidentiality. We would tell you that we are going to do this and we would then report it to someone who could help. Doing this would not affect the standard of care that you receive.



Part 2

What will happen if I don't want to carry on with the research?

You can stop being involved in the research at any time and do not have to give a reason why. This will not affect the standard of care that you receive.

What if there is a problem?

If you are unhappy with the research, ask to speak to the researchers and we will do our best to answer your questions. If you are still unhappy, and wish to complain formally, you can do this through the NHS complaints procedure or by contacting the Principal Supervisor, Dr. Pamela Dawson at Northumbria University.

Contact details


If you have any concerns or would like further information about the study, please feel free to contact the Chief Investigator, Jason Scott.

Jason Scott

Chief Investigator.

[address removed]


 [\[email address removed\]](#)

 [telephone number removed]

Dr. Pamela Dawson

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

What happens now?

Thank you for taking the time to read this information sheet. If you are interested in taking part in the study, please fill in the reply slip below within two weeks of receiving it. If you need help to fill in the reply slip please contact us, or ask the person that gave you the documents.



Once the reply slip is completed please return it to the person who originally gave it to you. It will then be passed securely to Jason Scott. Alternatively you can send it to Jason Scott yourself at the address above. Please do not complete the **Consent Form** at this time.

Jason Scott will then contact you to arrange an interview. Before the interview begins, you will be asked to fill out a **Consent Form**. A copy of the **Consent Form** has been provided for you to view. You do not need to fill this in before you have met with Jason Scott.

If you would like to read more about the project or the lay person's summary please contact Jason Scott.



I would be interested in taking part in the SURE CARE study, and hereby give permission to be contacted by a member of the research team. I understand that before taking part, I will need to fill in a consent form and that if I want I can withdraw from the study at any time.

Name _____

Signature _____

Date _____

Appendix 3

Phase 1 – Service User Consent Form



Consent Form for service users (P1)

Title of project: SURE CARE

Name of Chief Investigator: Jason Scott

Please
initial box

1. I confirm that I have read and understood the information sheet dated 16/10/2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.

☐

3. I understand that data collected during the study may be looked at by individuals from the North East Strategic Health Authority, from Northumbria University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data collected about me.

☐

4. I understand that direct quotes may be used, but that they will remain confidential and I will not be identifiable through them.

☐

Please turn over



5. I understand that if I tell you something during the study that suggests that I or someone else is at serious risk, you would then have to break confidentiality. I understand that you would tell me if you were going to do this and you would report it to someone who could help

☐

6. I understand that my interview will be recorded using a digital voice recorder. I also understand that I may request for the interviewer to take notes instead of recording the interview.

☐

7. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

___ / ___ / ___

Researcher Name

Date

Signature

Jason Scott

___ / ___ / ___


Contact Details

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 4

Phase 2 – Service User Invitation Letter



SURE CARE

[A Research Study]

Invitation letter to service users (P2)

Dear Service User,

You are invited to take part in the second part of this research study

We are doing some research on service user safety when going through a transfer in care. It is a major study funded by the NHS North East Strategic Health Authority and Northumbria University.

What will this part of the study do?

It will create a mechanism that will allow service users such as yourself to identify and report safety incidents, based on what you told us in the first part of the study. The aim of the study is to inform and improve practice on both a local and national level.

How could you take part?

If you are interested in taking part you will be invited to attend two collaborative conferences, where we will ask for your input into a mechanism that will enable service users to identify and report adverse events along with times that have worked well. This mechanism will be based on the results from the first part of the study, and will be developed during the conferences, which will include other service users and health professionals.

What to do if you are interested in taking part and want more information?

If you would like to find out more information about the SURE CARE study, please take the time to read the **Information Sheet** included with this letter. This will give you more information about the study. You may also contact the researchers directly to find out more information or to ask questions. The contact details of Jason Scott are at the end of this letter and in the information sheet.

Please turn over

Version: 1

Date produced: 16/10/2009



If you have decided you do not want to take part in the study, you do not need to do anything.

Thank you for taking the time to read this letter.

Contact Details


If you have any questions, please contact:

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 5

Phase 2 – Service User Information Sheet



SURE CARE

[A Research Study]

Information Sheet for service users (P2)

Part 1

We would like to invite you to join in this research project. Before you decide if you want to take part you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and talk to others about the study if you wish.

If you have any difficulties, or need other help to understand the information please contact us. Your participation could make a real difference to the quality of care provided, but take time to decide whether or not you would like to participate.

Below is a list of terms used in this document.

<i>Care transfer:</i>	This is when your care is passed from one service to another. Examples of this include being discharged from hospital or moving from one hospital to another.
<i>Service user:</i>	This is any person who comes into contact with the National Health Service (NHS). This includes patients, carers, family members and advocates.
<i>Adverse event:</i>	This is an incident or circumstance that could have or did lead to unintended or unexpected harm, loss or damage.
<i>Expert Patients:</i>	Expert patients have a high level of knowledge about health services. This is developed through personal experiences.



What is the purpose of the SURE CARE study?

At the moment there has been very little research looking at how service users perceive their safety when going through a care transfer. We have spoken with a variety of service users about what safe care feels like to them when going through a care transfer. We want to use this information to develop a mechanism to help service users to identify and report adverse events when undergoing a care transfer. We are very interested in receiving your input into this mechanism which we hope will improve the level of care provided to patients.

Why have I been invited to take part in SURE CARE?

You have been invited to take part as you were involved in the first part of the study and we are very interested in receiving your input into the creation of the identification and reporting mechanism.

Do I have to take part?

No, it is completely up to you to decide. We will explain the study to you in this Information Sheet. If you would like to take part based on the information provided, we will then ask you to sign the reply slip at the end of this Information Sheet to show you have agreed for a member of the research team to contact you to discuss the two collaborative conferences.

If you decide to take part and change your mind, you can withdraw without giving a reason. You can do this at any time during the process of your involvement.

If you decide not to take part, or change your mind at any time, there will be no undesirable consequences.

What will happen to me if I take part?

If you do decide to take part in the study, you will be invited to attend two collaborative conferences, each lasting approximately two hours that will also include other service users and health professionals involved in care transfers. During these conferences, we will ask for your input into a mechanism that will



enable service users to identify and report adverse events. You will also be presented with the findings of the first part of this study, which developed a service user definition of safety in care transfers. If you do not want to take part in this part of the study, you will still receive a summary of the findings and you can request a copy of the final report.

If you decide to take part in the study, a researcher will then contact you with information about when and where the conference will take place. You will also be asked your age, and if you have any disabilities or other requirements again in case anything has changed. This is to help us to know if we are speaking to a wide variety of people and to accommodate for any needs you may have. The information will not be linked back to you as an individual, but you don't have to answer any of the questions if you do not want to.

Will taking part cost me anything?

At no time will you be asked for any money or your bank details. Any money you spend on travel will be reimbursed.

How might taking part affect me?

This study will not involve any physical risks, and you will be reimbursed for any travel that you may undertake. You will not be identifiable from the first part of the study.

Will taking part in the project be private and confidential?

We will follow ethical and legal practice and all personal information about you will be handled in complete confidence. Direct quotes may be used, but you will not be identifiable through them. Due to the nature of a collaborative conference, it is not possible to ensure that you will remain anonymous. The collaborative conference will be recorded using a digital-voice recorder.

Some of the information that you give us will be used for an educational project, as one of the researchers (Jason Scott) is doing a PhD. This will also be treated confidentially.



All information will be stored on a secure computer within Northumbria University, and will only be accessible by Jason Scott, the Chief Investigator. All personal information will be destroyed when the study ends, and any written and recorded information will be destroyed six years after the study ends.

Breaking confidentiality

If you tell us something during the study that suggests you, or someone else, are at serious risk, we would then have to break confidentiality. We would tell you that we are going to do this and we would then report it to someone who could help.



Part 2

What will happen if I don't want to carry on with the research?

You can stop being involved in the research at any time and do not have to give a reason why.

What if there is a problem?

If you are unhappy with the research, ask to speak to the researchers and we will do our best to answer your questions. If you are still unhappy, and wish to complain formally, you can do this through the NHS complaints procedure or by contacting the Principal Supervisor, Dr. Pamela Dawson.

Contact details


If you have any concerns or would like further information about the study, please feel free to contact the principle researcher, Jason Scott.

Jason Scott

Chief Investigator.

[address removed]


 [\[email address removed\]](#)

 [telephone number removed]

Dr. Pamela Dawson

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

What happens now?

Thank you for taking the time to read this information sheet. If you are interested in taking part in the study, please fill in the reply slip below within two weeks of receiving it. If you need help to fill in the reply slip please contact us, or ask the person that gave you the documents.



Once the reply slip is completed please return it to the person who originally gave it to you. It will then be passed securely to Jason Scott. Alternatively you can send it to Jason Scott yourself at the address above. Please do not complete the **Consent Form** at this time.

Jason Scott will then contact you to discuss available times for the conference. Before the conference begins, you will be asked to fill out a **Consent Form**. A copy of the **Consent Form** has been has been provided for you to view. You do not need to fill this in before the conference.

If you would like to read more about the project, see the original project bid or the lay person's summary please contact Jason Scott.



I would be interested in taking part in the phase two of the SURE CARE study, and hereby give permission to be contacted by a member of the research team. I understand that before taking part, I will need to fill in a consent form and that if I want I can withdraw from the study at any time.

Name _____

Signature _____

Date _____

Appendix 6

Phase 2 - Service User Consent Form



Consent Form for service users (P2)

Title of project: SURE CARE

Name of Chief Investigator: Jason Scott

Please
initial box

1. I confirm that I have read and understood the information sheet dated 16/10/2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.

☐

3. I understand that data collected during the study may be looked at by individuals from the North East Strategic Health Authority, from Northumbria University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data collected about me.

☐

4. I understand that I may not remain completely anonymous during the collaborative conference, but that any information collected about me will be confidential. I also understand that the information will be collected using a digital voice recorded and note-taking.

☐

Please turn over



5. I understand that if I tell you something during the study that suggests that I or someone else is at serious risk, you would then have to break confidentiality. I understand that you would tell me if you were going to do this and you would report it to someone who could help

☐

6. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

___ / ___ / ___

Researcher Name

Date

Signature

Jason Scott

___ / ___ / ___


Contact Details

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 7

Phase 2 – Expert Patient Invitation Letter



SURE CARE

[A Research Study]

Invitation letter to expert patients

Dear Service User,

You are invited to take part in this research study

We are doing some research on service user safety when going through a transfer in care. It is a major study funded by the NHS North East Strategic Health Authority and Northumbria University.

What will this study do?

It will look at what makes service users feel safe when they are going through a transfer in their care, and use this to create a mechanism that will allow service users to identify and report safety incidents. The aim of the study is to inform and improve practice on both a local and national level.

How could you take part?

If you are interested in taking part you will be invited to attend two collaborative conferences, where we will ask for your input into a mechanism that will enable service users to identify and report adverse events. This mechanism will be based on service user definitions of safety, and will be developed during the conferences, which will include other service users and health professionals.

What to do if you are interested in taking part and want more information?

If you would like to find out more information about the SURE CARE study, please take the time to read the **Information Sheet** included with this letter. This will give you more information about the study. You may also contact the researchers directly to find out more information or to ask questions. The contact details of Jason Scott are at the end of this letter and in the information sheet.

Please turn over



If you have decided you do not want to take part in the study, you do not need to do anything.

Thank you for taking the time to read this letter.


Contact Details

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 8

Phase 2 – Expert Patient Information Sheet



SURE CARE

[A Research Study]

Information Sheet for expert patients

Part 1

We would like to invite you to join in this research project. Before you decide if you want to take part you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and talk to others about the study if you wish.

If you have any difficulties, or need other help to understand the information please contact us. Your participation could make a real difference to the quality of care provided, but take time to decide whether or not you would like to participate.

Below is a list of terms used in this document.

<i>Care transfer:</i>	This is when your care is passed from one service to another. Examples of this include being discharged from hospital or moving from one hospital to another.
<i>Service user:</i>	This is any person who comes into contact with the National Health Service (NHS). This includes patients, carers, family members and advocates.
<i>Adverse event:</i>	This is an incident or circumstance that could have or did lead to unintended or unexpected harm, loss or damage.
<i>Expert Patients:</i>	Expert patients have a high level of knowledge about health services. This is developed through personal experiences.



What is the purpose of the SURE CARE study?

At the moment there has been very little research looking at how service users perceive their safety when going through a care transfer. We have spoken with service users about what safe care feels like to them when going through a care transfer. We want to use this information to develop a mechanism to help service users to identify and report adverse events when undergoing a care transfer. We are very interested in receiving your input into this mechanism which we hope will improve the level of care provided to patients.

Why have I been invited to take part in SURE CARE?

You have been invited to take part as you are currently part of an advisory panel to the Patient Safety Action Team at the North East Strategic Health Authority in the form of the Safer Care Patient, Carer and Engagement (PCPE) network.

Do I have to take part?

No, it is completely up to you to decide. We will explain the study to you in this Information Sheet. If you would like to take part based on the information provided, we will then ask you to sign the reply slip at the end of this Information Sheet to show you have agreed for a member of the research team to contact you to discuss the two collaborative conferences.

If you decide to take part and change your mind, you can withdraw without giving a reason. You can do this at any time during the process of your involvement.

If you decide not to take part, or change your mind at any time, there will be no undesirable consequences.

What will happen to me if I take part?

If you do decide to take part in the study, you will be invited to attend two collaborative conferences, each lasting approximately two hours that will also include other service users and health professionals involved in care transfers. During these conferences, we will ask for your input into a mechanism that will



enable service users to identify and report adverse events. You will also be presented with the findings of the first part of this study, which developed a service user definition of safety in care transfers.

If you decide to take part in the study, a researcher will then contact you with information about when and where the conference will take place. You will also be asked your age, gender, ethnicity, and if you have any disabilities or other requirements. This is to help us to know if we are speaking to a wide variety of people and to accommodate for any needs you may have. The information will not be linked back to you as an individual, but you don't have to answer any of the questions if you do not want to.

Will taking part cost me anything?

At no time will you be asked for any money or your bank details. Any money you spend on travel will be reimbursed.

How might taking part affect me?

This study will not involve any physical risks, and you will be reimbursed for any travel that you may undertake.

Will taking part in the project be private and confidential?

We will follow ethical and legal practice and all personal information about you will be handled in complete confidence. Direct quotes may be used, but you will not be identifiable through them. Due to the nature of a collaborative conference, it is not possible to ensure that you will remain anonymous. The collaborative conference will be recorded using a digital-voice recorder.

Some of the information that you give us will be used for an educational project, as one of the researchers (Jason Scott) is doing a PhD. This will also be treated confidentially.

All information will be stored on a secure computer within Northumbria University, and will only be accessible by Jason Scott, the Chief Investigator. All personal information will be destroyed when the study ends, and any written and recorded information will be destroyed six years after the study ends.



Breaking confidentiality

If you tell us something during the study that suggests you, or someone else, are at serious risk, we would then have to break confidentiality. We would tell you that we are going to do this and we would then report it to someone who could help.



Part 2

What will happen if I don't want to carry on with the research?

You can stop being involved in the research at any time and do not have to give a reason why.

What if there is a problem?

If you are unhappy with the research, ask to speak to the researchers and we will do our best to answer your questions. If you are still unhappy, and wish to complain formally, you can do this through the NHS complaints procedure or by contacting the Principal Supervisor, Dr. Pamela Dawson.

Contact details


If you have any concerns or would like further information about the study, please feel free to contact the principle researcher, Jason Scott.

Jason Scott

Chief Investigator.

[address removed]


 [\[email address removed\]](#)

 [telephone number removed]

Dr. Pamela Dawson

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

What happens now?

Thank you for taking the time to read this information sheet. If you are interested in taking part in the study, please fill in the reply slip below within two weeks of receiving it. If you need help to fill in the reply slip please contact us, or ask the person that gave you the documents.



Once the reply slip is completed please return it to the person who originally gave it to you. It will then be passed securely to Jason Scott. Alternatively you can send it to Jason Scott yourself at the address above. Please do not complete the **Consent Form** at this time.

Jason Scott will then contact you to discuss available times for the conference. Before the conference begins, you will be asked to fill out a **Consent Form**. A copy of the **Consent Form** has been has been provided for you to view. You do not need to fill this in before the conference.

If you would like to read more about the project, see the original project bid or the lay person's summary please contact Jason Scott.



I would be interested in taking part in the SURE CARE study, and hereby give permission to be contacted by a member of the research team. I understand that before taking part, I will need to fill in a consent form and that if I want I can withdraw from the study at any time.

Name _____

Signature _____

Date _____

Appendix 9

Phase 2 – Expert Patient Consent Form



Consent Form for expert patients

Title of project: SURE CARE

Name of Chief Investigator: Jason Scott

Please
initial box

1. I confirm that I have read and understood the information sheet dated 16/10/2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.

☐

3. I understand that data collected during the study may be looked at by individuals from the North East Strategic Health Authority, from Northumbria University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data collected about me.

☐

4. I understand that I may not remain completely anonymous during the collaborative conference, but that any information collected about me will be confidential. I also understand that the information will be collected using a digital voice recorded and note-taking.

☐

Please turn over



5. I understand that if I tell you something during the study that suggests that I or someone else is at serious risk, you would then have to break confidentiality. I understand that you would tell me if you were going to do this and you would report it to someone who could help

☐

6. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

___ / ___ / ___

Researcher Name

Date

Signature

Jason Scott

___ / ___ / ___


Contact Details

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 10

Phase 2 – Healthcare Professional Invitation Letter



SURE CARE

[A Research Study]

Invitation letter to staff members

Dear Member of Staff,

You are invited to take part in this research study

We are doing some research on service user safety when going through a transfer in care. It is a major study funded by the NHS North East Strategic Health Authority and Northumbria University.

What will this study do?

It will look at what makes service users feel safe when they are going through a transfer in their care, and use this to create a mechanism that will allow service users to identify and report safety incidents. The aim of the study is to inform and improve practice on both a local and national level.

How could you take part?

If you are interested in taking part you will be invited to attend two collaborative conferences, and to pilot a mechanism that will allow service users to identify and report safety incidents when going through a care transfer. This mechanism will be based on service user definitions of safety, and will be developed during the conferences, which will include service users and expert patients.

What to do if you are interested in taking part and want more information?

If you would like to find out more information about the SURE CARE study, please take the time to read the **Information Sheet** included with this letter. This will give you more information about the study. You may also contact the researchers directly to find out more information or to ask questions. The contact details of Jason Scott are at the end of this letter and in the information sheet.

Please turn over



If you have decided you do not want to take part in the study, you do not need to do anything.

Thank you for taking the time to read this letter.


Contact Details

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 11

Phase 2 – Healthcare Professional Information Sheet



SURE CARE

[A Research Study]

Information Sheet for members of staff

Part 1

We would like to invite you to join in this research project. Before you decide if you want to take part you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and talk to others about the study if you wish.

If you have any difficulties, or need other help to understand the information please contact us. Your participation could make a real difference to the quality of care provided, but take time to decide whether or not you would like to participate.

Below is a list of terms used in this document.

<i>Care transfer:</i>	This is when your care is passed from one service to another. Examples of this include being discharged from hospital or moving from one hospital to another.
<i>Service user:</i>	This is any person who comes into contact with the National Health Service (NHS). This includes patients, carers, family members and advocates.
<i>Adverse event:</i>	This is an incident or circumstance that could have or did lead to unintended or unexpected harm, loss or damage.
<i>Expert Patients:</i>	Expert patients have a high level of knowledge about health services. This is developed through personal experiences.



What is the purpose of the SURE CARE study?

At the moment there has been very little research looking at how service users perceive their safety when going through a care transfer. We have spoken with service users about what safe care feels like to them when going through a care transfer. We want to use this information to develop a mechanism to help service users to identify and report adverse events when undergoing a care transfer. We are very interested in receiving your input into this mechanism which we hope will improve the level of care provided to patients.

Why have I been invited to take part in SURE CARE?

You have been invited to take part as you are involved in care transfers as part of your working practice. Your employer understands the requirements of the study and has given us permission to approach you.

Do I have to take part?

No, it is completely up to you to decide. We will explain the study to you in this Information Sheet. If you would like to take part based on the information provided, we will then ask you to sign the reply slip at the end of this Information Sheet to show you have agreed for a member of the research team to contact you to discuss the two collaborative conferences.

If you decide to take part and change your mind, you can withdraw without giving a reason. You can do this at any time during the process of your involvement.

If you decide not to take part, or change your mind at any time, there will be no undesirable consequences.

What will happen to me if I take part?

If you do decide to take part in the study, you will be invited to attend two collaborative conferences, each lasting approximately two hours that will also include service users and expert patients. During these conferences, we will ask for your input into a mechanism that will enable service users to identify and report adverse events. You will also be presented with the findings of the



first part of this study, which developed a service user definition of safety in care transfers. You will then be asked to pilot the mechanism and feedback your findings at the following collaborative conference.

If you decide to take part in the study, a researcher will then contact you with information about when and where the conference will take place. You will also be asked your age, gender, ethnicity, and if you have any disabilities or other requirements. This is to help us to know if we are speaking to a wide variety of people and to accommodate for any needs you may have. The information will not be linked back to you as an individual, but you don't have to answer any of the questions if you do not want to.

Will taking part cost me anything?

At no time will you be asked for any money or your bank details. Any money you spend on travel will be reimbursed.

How might taking part affect me?

This study will not involve any physical risks, and you will be reimbursed for any travel that you may undertake.

Will taking part in the project be private and confidential?

We will follow ethical and legal practice and all personal information about you will be handled in complete confidence. Direct quotes may be used, but you will not be identifiable through them. Due to the nature of a collaborative conference, it is not possible to ensure that you will remain anonymous. The collaborative conference will be recorded using a digital-voice recorder.

Some of the information that you give us will be used for an educational project, as one of the researchers (Jason Scott) is doing a PhD. This will also be treated confidentially.

All information will be stored on a secure computer within Northumbria University, and will only be accessible by Jason Scott, the Chief Investigator. All personal information will be destroyed when the study ends, and any written and recorded information will be destroyed six years after the study ends.



Breaking confidentiality

If you tell us something during the study that suggests you, or someone else, are at serious risk, we would then have to break confidentiality. We would tell you that we are going to do this and we would then report it to someone who could help.



Part 2

What will happen if I don't want to carry on with the research?

You can stop being involved in the research at any time and do not have to give a reason why.

What if there is a problem?


If you are unhappy with the research, ask to speak to the researchers and we will do our best to answer your questions. If you are still unhappy, and wish to complain formally, you can do this through the NHS complaints procedure or by contacting the Principal Supervisor, Dr. Pamela Dawson.

Contact details

If you have any concerns or would like further information about the study, please feel free to contact the principle researcher, Jason Scott.


Jason Scott,
Chief Investigator.
[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Dr. Pamela Dawson,
[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

What happens now?

Thank you for taking the time to read this information sheet. If you are interested in taking part in the study, please fill in the reply slip below within two weeks of receiving it. If you need help to fill in the reply slip please contact us, or ask the person that gave you the documents.



Once the reply slip is completed please return it to the person who originally gave it to you. It will then be passed securely to Jason Scott. Alternatively you can send it to Jason Scott yourself at the address above. Please do not complete the **Consent Form** at this time.

Jason Scott will then contact you to discuss available times for the conference. Before the conference begins, you will be asked to fill out a **Consent Form**. A copy of the **Consent Form** has been has been provided for you to view. You do not need to fill this in before the conference.

If you would like to read more about the project, see the original project bid or the lay person's summary please contact Jason Scott.



I would be interested in taking part in the SURE CARE study, and hereby give permission to be contacted by a member of the research team. I understand that before taking part, I will need to fill in a consent form and that if I want I can withdraw from the study at any time.

Name _____

Signature _____

Date _____

Appendix 12

Phase 2 – Healthcare Professional Consent Form



Consent Form for members of staff

Title of project: SURE CARE

Name of Chief Investigator: Jason Scott

Please
initial box

1. I confirm that I have read and understood the information sheet dated 16/10/2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

☐

3. I understand that data collected during the study may be looked at by individuals from the North East Strategic Health Authority, from Northumbria University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data collected about me.

☐

4. I understand that I may not remain completely anonymous during the collaborative conference, but that any information collected about me will be confidential. I also understand that the information will be collected using a digital voice recorded and note-taking.

☐

Please turn over



5. I understand that if I tell you something during the study that suggests that I or someone else is at serious risk, you would then have to break confidentiality. I understand that you would tell me if you were going to do this and you would report it to someone who could help

☐

6. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

___ / ___ / ___

Researcher Name

Date

Signature

Jason Scott

___ / ___ / ___


Contact Details

Jason Scott

Chief Investigator.

[address removed]

 [\[email address removed\]](#)

 [telephone number removed]

Appendix 13

Phase 1 –Interview Schedule

Interview schedule

Discover

1. What sort of experience do you have of going through care transfers?

Prompt:

- How many have you been through?
- Have these been quite recently or were they a long time ago?
 - Where were you transferred from and to, and by whom?
- Who was involved in the care transfer?
 - Were any members of your family present?
 - Which staff were involved at the start, during and after?

2. Did you feel safe during any of these transfers?

Prompt:

- Where did you transfer from and to in this instance?
- What was it that made you feel particularly safe?
 - Is this something of importance to you?
 - If yes, why?
 - If no, why not?
- What sort of effect, if any, did this have on you?
- How does this reflect your other experiences of care transfers?

3. Have you had any experiences when you've felt unsafe?

- Where did you transfer from and to in this instance?
- What was it that made you feel unsafe?
 - What could have been done to make you feel safe?

4. Generally how do you feel about being transferred?

Prompt:

- Can you please elaborate on this
 - What makes it good or bad,
 - Was there anything in particular that made it memorable?

5. If someone was to talk about safety or being safe, what does this mean to you?

Prompt:

- Can you please elaborate on this?
- How does this relate to your experiences of care transfers?
 - [If participant doesn't understand this, try rephrasing the original question]

6. Does safety cross your mind when you are going through a care transfer?

Prompt:

- Why do you think this is?
- Why does it not cross your mind?



7. Can you think of any other times you've felt safe when going through a care transfer?

Prompt:

- Where did you transfer from and to?
- What made you feel particularly safe on that occasion?
 - Was something of importance to you?
 - If yes, why?
 - If no, why not?
- What sort of effect, if any, did this have on you?

8. [If other people are present] Were you involved in the process of [participant's name] being transferred?

Prompt:

- If yes, what was your level of involvement?
 - Was there anything that helped to make you feel that [participant's name] was safe?
 - Did you have any concerns about [participant's name's] safety?
- If no, can we speak hypothetically about if you were involved?
 - Was there anything that would have helped to make you feel that [participant's name] was safe?
 - Did you have any concerns about [participant's name's] safety?

9. [If other people are present] Was [Participant's name's] safety something that you thought about when they were being transferred?

Prompt:

- If yes, in what way did you think about safety?
 - Why were you thinking about [participant's name's] safety?
 - Was there anything that could have been done to change this?
- If no, was there any reason why not?



Dream

- 1. If you were to go through a care transfer next week, what could be done to make you feel safe?**

Prompt:

- Why would this make you feel safe?
- Is this something that is of importance to you?
 - If yes, why?
 - If no, why not?

- 2. What else would make you feel safe?**

Prompt:

- Why would this make you feel safe?
- Is this something that is of importance to you?
 - If yes, why?
 - If no, why not?

- 3. Can you think of any ways that care transfers could be improved to make you feel more safe?**

Prompt:

- This could be something which is already making you feel safe, but could be slightly improved
- How would this make you feel safer?

- 4. Are you aware of any means for you to tell someone about how the process has been for you?**

Prompt:

- If yes:
 - How would you go about this?
 - Have you done this in the past?
 - If yes, what exactly did you do?
 - How did you find the experience of telling someone?
 - Is this something that you think is important?
 - Why?
- If no:
 - Do you think that you should be able to tell someone about how the process has been?
 - Why?

- 5. Is there anything else you would like to add?**

Prompt:

- Expand on something that you've told me
- You might have remembered something else of importance to you

Appendix 14

Phase 2 – Workshop 1 Agenda



SURE CARE Phase 2: Development of a service user identification and reporting mechanism

Workshop 1 Agenda

1300 – 1330	Lunch
1330 – 1400	Introduction to the day and feedback of Phase 1 results
1400 – 1430	First break-off session: What will the mechanism look like?
1430 – 1450	Feedback from first break-off session
1450 – 1500	Overview of first break-off session
1500 – 1530	Second break-off session: How will the mechanism fit in with current systems? / refreshments
1530 – 1550	Feedback from second break-off session
1530 – 1600	Overview of second break-off session / closing comments

Appendix 15

Phase 2 – Workshop 2 Agenda



SURE CARE Phase 2: Development of a service user reporting mechanism for instances of safe and unsafe care

Workshop 2 Agenda

0930 – 1000	Introduction
1000 – 1030	Break-off session 1: Thinking differently: divergent thinking
1030 – 1045	Feedback from break-off session 1
1045 – 1100	Break
1100 – 1145	Break-off session 2: Convergent thinking: Pulling the ideas back together
1145 – 1200	Feedback from break-off session 2
1200 – 1230	Summary / Closing points

****Lunch will be provided in the canteen outside of the room at 1230****

Appendix 16

Scott, J., Dawson, P. & Jones, D. (2011). Do older patients' perceptions of safety highlight barriers that could make their care safer during organisational care transfers? BMJ Quality and Safety, doi: 10.1136/bmjqs-2011-000300

Do older patients' perceptions of safety highlight barriers that could make their care safer during organisational care transfers?

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ABSTRACT

Background: Healthcare is a series of complex, interwoven systems in which any discontinuities of care may affect the safety of patients, who have been reported to perceive safety differently to clinicians. This study aimed to explore patient perceptions of safety and identify how they can be used to construct additional barriers to reduce safety incidents within organisational care transfers, which are known to be high in risk.

Design: Appreciative Inquiry (AI) methodology was used to develop semi-structured interviews, using the Discover and Dream processes of AI. Fourteen patients (four men, 10 women; average age 76.2 years) were purposively recruited from NHS community care teams, social care homes and private nursing homes based on their experience of going through organisational care transfers. Thematic analysis was used to highlight key themes, which participants verified.

Findings: Communication, responsiveness and avoidance of traditional safety risks were identified as being important for patients to feel safe. Communication and responsiveness were mapped onto the Swiss-Cheese model of safety, presenting two new barriers to safety incidents. Traditional risks and the role of trust are discussed in relation to patients feeling safe.

Conclusion: Perceptions of safety such as communication and responsiveness were similar to those found in previous studies. Mapping these perceptions onto the Swiss-Cheese model of safety identifies how further defences, barriers and safeguards can be constructed to make people feel safer by reinforcing communication and responsiveness. Traditional risks are widely published, but the identification by patients reinforces the role they can play in identifying and reporting these risks.

INTRODUCTION

Patient safety has received much attention since the publications of *To Err is Human*¹ and *An Organisation with a Memory*,² which identify that healthcare as a whole is intrinsically risky. The exploration and detection of gaps in healthcare, defined as discontinuities of care,³ can guide safety improvement efforts.

This is especially important in organisational care transfers (OCTs) with the rate of adverse events estimated to be approximately 20%,^{4–6} twice the rate of other healthcare settings.^{1 2 7–9} Falls,¹⁰ medication errors^{11 12} and interprofessional communication deficiencies^{13 14} are the most common reported adverse events in OCTs.

Despite an increasing body of literature exploring safety in transfers, which ranged from individual handoffs^{15 16} to organisational transfers,^{17 18} there has been no research known to the authors that considers patient definitions of safety in OCTs. It is thought that patients can play a role in their own safety,^{19–25} with their definitions of safety differing to those of clinicians.^{26–28}

There has been no theoretical exploration of how patient perceptions contribute to established models of patient safety, such as the Swiss-Cheese model.²⁹ According to this model, hazards are a natural occurrence within healthcare that are continually changing and moving. To reduce the chances of a hazard leading to a patient safety incident, defences, barriers and safeguards are necessary. It is therefore necessary to identify different types of defences, barriers and safeguards that could be implemented into healthcare organisations to make them safer (box 1).

Original research

Box 1 Definition of an organisational care transfer

An organisational care transfer is defined within this study as the transfer of a patient from one setting to another, where either or both the organisations are healthcare providers. This includes the admission, journey and discharge processes, but not the full stay within the healthcare organisation.

As such, the aim of this study was to

- explore the concepts, explanations and terms used by patients when talking about safety in OCTs;
- explore how defences, barriers, and safeguards can be constructed in OCTs through the provision of patient-defined safe care.

Methodology

Appreciative Inquiry (AI) has been identified as a method of organisational development,^{30 31} but also as an interview tool that is effective at generating rich data both externally to^{32 33} and internally within healthcare.^{34 35} AI is based on the assumption that within any human system there is always something that works well but can be further improved,^{31 32 36} which in this study centres on an exploration of what makes people feel safe.

A semi-structured interview schedule was developed based on the Discover and Dream processes³¹ of AI which explored the past experiences and future needs of patients respectively. It is acknowledged that by using an interpretive methodology, participants may have their own perceptions of safety that have a negative focus, in particular as participants will be required to pay attention to negative experiences in order to identify what is a positive experience. It was therefore important not to disregard these negative experiences in the data analysis, but to build upon them to identify potential barriers.³¹ The use of qualitative interviews also allows for new concepts to arise that have previously not been considered,³⁷ and by conducting dyadic interviews, there is an opportunity to generate a richer understanding of needs and experiences than with single participants.³⁸

Participants

Fourteen participants were recruited from three community care teams spanning two NHS trusts (n=7), two City Council Resource Centres (n=3) and two private nursing and residential care homes (n=3). A further participant, who was not under the care of any of these organisations, was also recruited via snowball sampling. She was a family member of a current participant who, while acting in the capacity of a family member and carer during an interview, fulfilled the recruitment criteria and offered to share her own

experiences of being transferred. The participants were aged between 56 and 88 years (mean age 76.2), of which 10 were women and four were men. All participants were white British. Information on the most recent transfer was not collected as it was important to capture the OCT that mattered most to the participants.

Recognising that the nature of care transfers means that often patients do not go through the process alone, participants were asked to invite family members, carers or advocates who experienced the journey with them to participate in the interview. This approach enabled them to remember aspects of certain events that the patient had not and to validate what the patients were reporting. Two participants had family members present, while one participant had a family friend present. Full consent was obtained from everyone who participated in the interview.

NHS community care teams were selected at the point of the NHS Research and Design (R&D) application by the respective R&D managers to purposively recruit patients based on the inclusion criteria (table 1).

A further three participants were approached during the period of data collection prior to all 14 participants being recruited, but were not included in the study. Contact details were incorrect for one, another cancelled the interview due to illness and a third was deemed unable to give informed consent prior to the start of the interview.

Data collection

The data were collected through semi-structured interviews conducted between February and March 2010. Interviews lasted between 20 and 52 min, with an average length of 39 min. One participant requested that the interview was not recorded, and instead notes were taken and verified on interview completion. The interviews were conducted at a location convenient to the participants, which was always their current residence.

Table 1 Inclusion and exclusion criterion for participants in phase 1

Inclusion criteria	Exclusion criteria
Aged >17	Aged <18
Able to give informed consent	Unable to give informed consent
Undertaken an organisational care transfer in the last 6 months, or	No experience of organisational care transfers
Extensive experience of organisational care transfers (more than two in the last 5 years)	

A topic guide was developed to give structure to the interviews. Questions were open ended and encompassed the principles of the AI methodology, particularly the Discover and Dream processes. The interview was structured to explore the following:

- ▶ the types of OCTs participants had been through;
- ▶ if participants felt safe during the OCTs;
- ▶ what safety means to participants;
- ▶ what would make participants feel safer in future OCTs.

Twenty interviews were anticipated at the outset; however data collection ceased after 14 interviews because recurrent themes were being supported rather than new themes being identified.

Data analysis

The interview recordings were transcribed verbatim, and NVivo 8 was used as a tool to systematically code and analyse the data into emergent themes. Although the interview was split into the Discover and Dream processes of AI, thematic analysis was used to highlight key themes from across the two processes. Connections between the top two levels of subcategories contributing to each theme were mapped based on interview data.

Data verification and validity

Participant verification has been identified as an appropriate method of verifying findings and assessing validity in qualitative research.³⁹ Out of the 14 participants, six were revisited after data analysis had been completed. Each of the six verified that the themes that had been captured were accurate, and they felt that they did not have anything more to add. From the other eight participants, two preferred that the findings were posted out to them and six were not contactable via telephone. The findings were posted to their last known address with a letter explaining that if anything was incorrect then they should contact the researcher. No contact has been made in the 6 months since the letters were sent.

FINDINGS

Four key themes were identified: communication, responsiveness, trust and traditional safety risks. 'Communication' included being informed, having a means to contact a healthcare professional, being friendly and reassuring, apologising after an incident and listening. The role of communication is widely recognised in patient safety literature, particularly within human factors⁴⁰ and the role that it plays in ensuring the safe transfer of patients.^{13 15} It has also been identified in previous research exploring patient perceptions of safety.²⁶

Listening was also an important component of 'responsiveness', which included responding to the individual needs of the patient, having short waiting times and making the transfer an easy process. Responding to individual needs is a central part of providing patient-centred care, which has been reported to improve health status and efficiency of care.⁴¹ Long waiting times have been reported to have a negative effect on healthcare,²⁸ potentially relating to how safe patients feel, while overcrowding of emergency departments threatens patient safety.⁴²

'Trust' was inherent in participants regardless of experiences of care, originating intrinsically and from the knowledge that healthcare professionals were sufficiently trained. Another sign of trust was the participants' inclination to make excuses for the healthcare professionals when something went wrong. Patients with high levels of trust in their healthcare professionals feel more safe,⁴³ whereas patients with experience of an adverse event lose trust.⁴⁴

The 'traditional safety risks' discussed included physical safety during the transfer, falls, healthcare-acquired infections, receiving an adequate standard of care, missed diagnosis, medication concerns and excessively painful procedures. There is an extensive amount of literature exploring each of these issues, moving towards including them in a universal definition of safety.^{45–47}

Box 2 provides examples of data illustrating the four themes.

DISCUSSION

Four dimensions of care related to safety have been identified when exploring how patients perceive safety in OCTs, including traditional safety risks, communication, responsiveness and trust. The use of the term 'traditional safety risks' is acknowledged to be a catch-all theme to further demonstrate that patients are able to identify some of the same hazards as clinicians, such as medication issues, falls and healthcare-acquired infections, which were recognised in other studies.^{26 27 48}

It has been identified that patient definitions of safety may be broader than clinician definitions.^{26 28} The findings from this study support recent evidence that communication and patient centredness are important in making people feel safe.⁴⁹ It is proposed that communication and responsiveness are important components to providing safe care to the patient when going through an OCT, while there has been a call to apply theories more widely to patient safety practices.⁵⁰ Applying communication and responsiveness to Reason's Swiss-Cheese model of safety,²⁹ additional defences, barriers or safeguards can be constructed so as to reduce the chances of a hazard resulting in an adverse event.

Original research

Box 2 Some examples of how patients perceive safety.

Communication

On that admissions ward they're so busy they don't have the time to come say to you every hour, every couple of hours that, "it shouldn't be too much longer," or, "it's going to be a while." Really just to keep you informed. [P13]

You do feel safe when you're leaving your home if you're with these people. It's not as if they're a stranger to you, they actually put you at your ease so [they] make you feel safe. [P08]

When I say I feel safe, I feel safe with them there so I can call them at any time, the rapid response team. [P14]

I try to find out as much as I could about where I was supposed to be going before I say I would go. [P04]

Responsiveness

I felt that they felt "there's nothing wrong with her" ... they didn't even open the back door ... And bearing in mind I hadn't a breath in me. And they're saying "go on you can do it, go on you can do it." Like you know, and I did, but when I got in he had to put an oxygen mask on me. [P14]

I feel quite safe in their hands. If I don't I tell them, and whether they appreciate that or not, I don't know. I just sort of say "well if I'm not very happy with that do you think we can do ..." and we just have a little private conversation between the staff and me. And we arrive at what we both agree on. [P04]

We just had to call out and there'd be somebody there straight away if you needed them. Quite safe both in the ambulance and in the hospital. [P03]

Trust

I just put myself in their hands. I know that they'll get me there safely. I don't know why, I just trust people. [P02]

I think that when you're poorly you're at your lowest ebb. And the reassurance in knowing that you have trained people with you, yes that does make you feel safe. [P10]

Being safe as I say, it's just something that I assume. I mean, I presume I'm in capable hands, I presume they're capable people that will get me from A to B in a comfortable manner. [P09]

I think they do as much as they can with the resources that they have. I don't think they could do any more really. [P13]

Traditional safety risks

I don't think it should happen to anyone that is incapable of looking after themselves, to be sent home on their own to an empty house without any care support in. [P06]

I don't feel safe in the house now because I've been taking epileptic fits ... I can't remember what tablets I've got to take or when I've got to take them. And if I've took them, have I took them? [P11]

The nurse or somebody helped [her daughter] to put her in the car, and she was yelping with the pain ... they took her back to A and E only to find when she'd had that fall three weeks previous, she'd broke her hip. [P04's carer]

Within OCTs, clinicians should adhere to the individual elements of the communication and responsiveness themes identified in this study (figure 1), which would enable them to provide safer care by involving the patient as an extra safety buffer.²⁰ More specifically, communicating with and being responsive to the patient can increase their involvement in their healthcare, thus encouraging them to become active participants rather than passive recipients, and subsequently increasing their safety. When clinicians do not adhere to these, holes in the Swiss-Cheese may open up, allowing for a hazard to become an adverse event.

The importance of having the patient as an additional buffer is emphasised in OCTs, where many gaps in safety occur,³ and there are fewer technical defences. However it must be remembered that not all patients are able or willing to be involved in their own safety,²⁰ such as in emergency transfers.

The role of trust within safety has previously been seen to be an outcome of a patient safety incident, with patients potentially losing trust in their clinicians as a result of a safety incident,⁵¹ although this has been contested.⁵² The role of trust within this study was twofold. First, participants often made excuses for clinicians, possibly as a result of cognitive dissonance; a feeling of unease when considering the people trying to help them may in fact harm them, or it could be alluding to their ability to identify latent conditions in current healthcare systems,²⁹ for example, resource limitations, that have the potential to result in adverse events. If the last point is correct it supports the notion that patients can play a role in identifying and reporting safety incidents.^{19 24 27}

Second, trust helped to make patients feel safer, which potentially acts as a hindrance towards becoming involved in their own safety. By applying communication and responsiveness to the Swiss-Cheese model of safety,

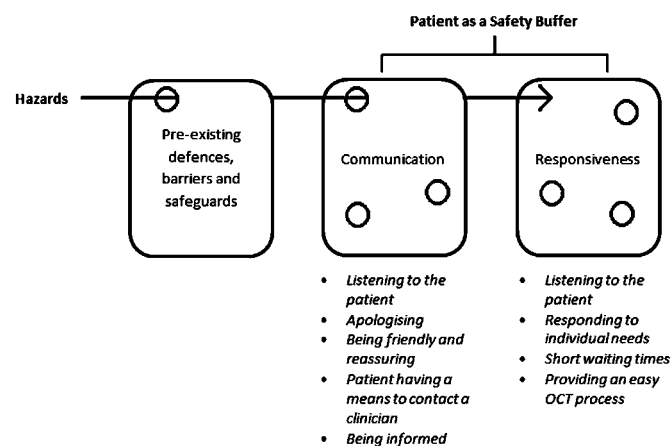


Figure 1 The patient's role as a safety buffer in the Swiss-Cheese model of safety.²⁹

it can be argued that patients can act as safety buffers in relation to these. Therefore the same components of the model, such as active failures and latent conditions, must also be applied to patient involvement in safety. Trust can be seen to be a latent condition, defined as an 'inevitable resident pathogen', which leads to holes or weaknesses in the defences,²⁹ potentially reducing how involved patients become in their safety and subsequently their safety itself. The exact relationship between trust as an outcome of as well as a hindrance to safety needs further exploration. In addition, the implications of trust being a latent condition that influences patient involvement in their own safety requires investigation.

The findings from this study will inform the development of a patient-reporting tool that will enable patients, family members, carers or advocates to report instances of safe and unsafe care during OCTs based on the reported perceptions. This will allow service users to become involved in identifying strengths and weaknesses in the communication and responsiveness barriers contributing to their safety in OCTs (box 3).

Limitations

Patients are not always able to see what occurs out of their sight, and therefore any perceptions that they do have of safety may not always reflect those of their clinicians.²⁷ Further studies are required to help fill this knowledge gap and to explore how closely patient perceptions of safety are linked with clinician perceptions. This in turn may lead to an identification and reduction of potential organisational safety issues during patient transfers. However, regardless of any differences in perception, if patients perceive themselves to be unsafe then there is an issue that requires resolving.

A further limitation is that this study recruited from a small sample of older patients going through OCTs and therefore the findings may not be transferrable. Furthermore, the nature of the organisations that participants were recruited from meant that the average age of participants was higher than originally planned. Readers should take these limitations into consideration

when deciding if the findings can be transferred to their own circumstances.

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Competing interests None.

Ethics approval Sunderland Research Ethics Committee.

Provenance and peer review Not commissioned; externally peer reviewed.

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Box 3 How the findings can be transferred to other settings

These findings may be of relevance to clinicians operating in and around organisational care transfers, such as nurses, ambulance staff, community care teams and emergency departments. By communicating effectively and responding to the individual needs of the patient, clinicians will be constructing an additional safety buffer that may make their patients feel and be safer.

Original research

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